THE LEGAL RIGHTS OF SURGICAL PATIENTS ON THE DUTIES AND LIABILITIES OF SURGEONS IN NIGERIA

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CERTIFICATION

This is to certify that this thesis: **THE LEGAL RIGHTS OF SURGICAL PATIENTS ON THE DUTIES AND LIABILITIES OF SURGEONS IN NIGERIA** was written by OFOEGBU HELEN IHUNNA. It has been read and approved as meeting the requirement for the award of **DOCTOR OF PHILOSOPHY IN LAW.**

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ABSTRACT

The medical profession is one of the most sensitive careers because it deals with the survival of human beings. However, the medical experts, while discharging their duties are occasionally negligent in strict adherence to the established Professional Code of Conduct. In Nigeria, there exists a myriad of delinquencies in which the medical personnel involved go scot free because of legally perceived obstacles in enforcing such rights. Therefore, the objectives were to: (i) examine the adequacy of the legal framework on the liabilities of professional surgeons; (ii) analyse the legal implications of the breach of duty in the surgical profession; (iii) examine judicial attitude to the rights of a patient in surgical negligence; and (iv) measure the performance of surgeons in the discharge of their professional and legal obligations.

The study employed qualitative and quantitative methodology of legal research. For the qualitative aspect, doctrinal and non-doctrinal methods were used for the analysis. The doctrinal method placed reliance on both primary and secondary sources of law. The non-doctrinal involved interviews carried out on stakeholders. Seventy stakeholders (20 surgeons, 30 surgical patients and 20 surgical nurses) were interviewed in University College Hospital, Ibadan, University of Ilorin Teaching Hospital, Ilorin, National Hospital, Abuja and Abia State Teaching Hospital, Aba. These hospitals were chosen because of high calibre of surgeons and the number of surgeries being carried out each day. The quantitative aspect involved a field work, where copies of questionnaires were distributed to the respondents to ascertain the degree of negligence and assess the performance of surgeons in the discharge of their professional and legal obligations. Copies of 870 questionnaires were administered in the four hospitals, 800 were returned while 580 were found usable. Descriptive statistics tool was used to analyse the quantitative aspect of this work.

The findings of the study were that:

i. There was no adequate enabling laws to regulate medical practices in Nigeria especially in relation to surgeons' negligence;

ii. Medical negligence is the legal consequence of the breach of duty in medical profession, yet, this requires proof of certain elements which are usually difficult for patients;

iii. The judicial attitude has made access to justice to patients more tasking with stringent rules thereby leading to numerous cases being dismissed on grounds of technicalities and victims are left with no remedy whatsoever; and

iv. Surgeons are doing fairly well in the performance of their duties though there are rooms for improvement as 75.0% of patients revealed that the operation was properly carried out whereas 25.0% said their operations were not properly carried out. The surgeons responded that 59.5% of all the surgeries performed by them were successful.

The study concluded that inadequate legal framework on medical practice is inimical to the protection of patient's rights pertaining to cases of surgical negligence and performance of the duties of surgeons. The study therefore recommended that the existing laws be amended in terms of punishment for surgical negligence and general regulation of medical practice in Nigeria.

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DEDICATION

This work is dedicated to the Almighty God, the Alpha and Omega, who kept me alive. I equally dedicate it to my late parents, Mr. Dominic O. Obasi and Mrs. Felicia Onyewuchi Obasi for their inestimable love, without whom I would not have had any education as a woman.

I dedicate this work also to my husband, my precious and wonderful children who have made life much comfortable for me. May you all remain blessed in the Lord. Amen.

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LIST OF ABBREVIATIONS

1	ADR	-	Alternative Dispute Resolution
2.	AIDS	-	Acquired Immune Deficiency Syndrome
3.	BMA	-	British Medical Council
4	CFRN	-	Constitution of the Federal Republic of Nigeria
5.	CLR	-	Commonwealth Law Report
6.	CPA	-	Criminal Procedure Act
7	CPA	-	Consumer Protection Act
8.	ER	-	England Report
9.	HIV	-	Human Immune Virus
10.	HWC	-	Health Worker's Commission
11.	ICCPR	-	International Covenant on Civil and Political Rights
12.	JSC	-	Justice of the Supreme Court
13.	LFN	-	Laws of the Federation of Nigeria
14.	MDCN	-	Medical and Dental Council of Nigeria
15.	MDPA	-	Medical and Dental Practitioner's Act
16.	MDPDT	-	Medical and Dental Practitioner's Disciplinary Tribunal
17.	NCDRC	-	National Consumer Disputers Redressed Commission
18.	NLR	-	Nigeria Law Report
19.	NMA	-	Nigerian Medical Association
20.	NMLR	-	Nigeria Medical Law Report
21.	NWLR	-	Nigerian Weekly Law Report
22.	NSWCA	-	New South Wales Court of Appeal
23.	NSWLR	-	New South Wales Law Reports
24.	NSWSC	-	New South Wales Supreme Court
25.	QSC	-	Queens Supreme Court
26.	RSC	-	Rules of Supreme Court
27.	UCH	-	University College Hospital
28.	UITH	-	University of Ilorin Teaching Hospital
29.	UK	-	United Kingdom
30.	UNLR	-	United Nation Law Report
31.	US	-	United States
32.	WACA	-	West African Court of Appeal
33.	WHO	-	World Health Organization
34.	WMA	-	World Medical Association
35	WRLR	-	Western Region Law Report
36.	WRN	-	Western Region of Nigeria
37.	WWR	-	Western Weekly Reports

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LEGAL RIGHTS OF SURGICAL PATIENTS ON THE DUTIES AND LIABILITIES OF SURGEONS IN NIGERIA

CHAPTER ONE

GENERAL INTRODUCTION

I.1.0 INTRODUCTION

The very existence of human beings meant that from time to time man would require medical attention. So, the practice of medicine evolved from time of human creation, even though it may not be as sophisticated as it is today. Medicine like any other human endeavour, is practiced by human beings and human beings are liable to making mistakes in the discharge of their duties. Medical negligence results therefore from fallibility of human beings. Surgery emerged as a specialty of medicine. Surgeons who perform the duty are susceptible from time to time to making some mistakes either in the theatre or in the wards and clinics. It is such mistakes that are severally being referred to as surgical negligence. Yet, a surgeon usually does not assure his patients of the result and would not assure the patients full recovery in every case. Likewise, a surgeon does not usually guarantee that the result of surgery would invariably be beneficial, much less to the extent of 100 % for the patient.[1] What professionals normally say is that, while undertaking the performance of the task entrusted to him, he would be exercising his skill with reasonable competence.[2] However, a professional person and a client may enter into a

[1]Bettle, J (1987) "Suing Hospitals Direct whose Tort Was It Anyhow?" New Law Journal, Volume 13, pp 573-577; Binchy, W "Recent Developments in the Law Affecting General Practitioner's Liability to Their Patients" Paper, read at Dublin University, Trinity College, Law School, 18 February 1995; Bishop, W (1980) "Negligent Misrepresentation through Economic Eyes" The Law Quarterly Review. Volume 96, Part 3, pp 360-379; Bolt, D (198 9) "Compensating for Medical Mishaps - A Model 'No-Fault7 Scheme" New Law Journal, Volume 13 pp 109-110

[2] D. Harris, (1991) "The Pleas for Radical Reform of Personal Injury Law Will Not Be Silenced: Tort Law Reform in the United States" 11 *Oxford J. Leg. Studies*, , 407, at p. 407.

relationship in which a duty to take care is imposed upon the professional.[3] This duty may arise by virtue of an agreement between them or by operation of law. Either way, a failure to take care may result in an action for negligence being instituted by the client against the professional.[4]

The phenomenon of medical negligence therefore has existed for a long time both in First World States like the United Kingdom and the United States of America and in emerging economies like Nigeria. While in the developed countries, people are very much aware of their various rights and their system encourages them to know their rights and ensure that all reported cases are treated with every sense of urgency and or the seriousness they require. But in the developing countries like Nigeria people do not know their rights and there is paucity of information regarding professional negligence. When negligence occurs in other spheres of life it may be easily managed. But when it occurs in a surgical arena which deals with human life, it assumes a high level of criticality. Surgical negligence from time immemorial had occurred but in recent times people have tended to become more aware of the gravity of the situation and the consequences of such negligence. The responsibility of a surgeon is very enormous, and if only for that reason, he can, by the application of his knowledge and skill extend the life of a human being.

Medical profession is one of the noblest professions in the globe and the practice of medicine is a spiritual call to serve humanity. In the process of this service a lot of incidents or accidents may

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[3]Anon "Legislation on Medical Practice" The Irish Times, 6 December 1995; Anon (1994) "Medical Negligence BOLAM and Professional Practice" Medical Law Review, Volume 2, Number 2, pp 210- 213; Anon "Suits against Irish Doctors 4 0% Higher than m the U K " The Irish Times, 28 September 1995; Anon (1996) "The Evidentiary Use of the Ethics Codes m Legal Malpractice Erasing a Double Standard" Harvard Law Review, Volume 109, Number 5, pp 1102-1119; Anon (1995) "Treatment at Life's End" Irish Law Times, Volume 13 Number 9, pp 205; Banakas, E K (1985) "Professional Negligence The New Principles Considered" Solicitors7 Journal, Volume 129, Number 22, pp 372-374; Barker, K (1995) "N H S Contracting Shadows m the Law of Tort9" Medical Law Review, Volume 3, Number 2, pp 161- 176; Barry, H C P (1991) "Privilege, Confidentiality Between Solicitor and Client and the Computer" Law Society of Ireland Gazette, Volume 86, Number 1, pp 5-7; Baughen, S (1992) "The Will that Never Was ROSS v CAUNTERS extended" Professional Negligence, Volume 8, Number 3, pp 99-102

[4] Gupta, Kiran, (*2011* 2012) "The Standard of Care and Proof in Medical Profession: A Shift from Bolam to Bolitho", XIV-XV *National Capital Law Journal* 1.

occur; particularly in surgical arena. People believe that preventable injuries have been identified as strikingly common occurrence in all aspects of modern health care. The term Epidemic of error was devised in the United Kingdom as well as, in the United States of America. The Institute of medicine acting under the National Academy of sciences has identified errors in healthcare as leading cause of death and injury, comparable with that of road accident[5]. The precise extent of this problem is open to question, but it is beyond argument that an unacceptable number of people suffer serious harm or die as a result of some avoidable adverse events.

In many areas of human activity, there is a strong tendency to attribute blame for accidents, which on further investigation may be shown not to involve any culpable conduct. This is a particular issue in medical practice where the consequences of an error or a violation of rights may be very severe. In many civilized parts of the world this has gone hand in hand with a marked increase in surgical litigation reflecting heightened public concern over the level of iatrogenic harm.

The current standard by which negligence is assessed in the law is that of reasonableness in respect of knowledge, skill and care. However, a great deal depends on the way in which it is tested. An expert can hardly be expected to say that it is reasonable to give a patient a wrong drug. However, if a question is focused on the person who is a human being, and asks was this the sort of mistake a reasonable practitioner must make? The answer will be different. As we shall see, there is evidence that in fact all the doctors make slips/errors at some time or the other, including in drug administration. This problem affects all societies and what has been discussed here applies generally though, few applies to specific countries. The legal principles involved are

[5] I.T. Kohn, J.M. Corrigan and M.S. Donaldson (eds) To err is human; building a safer system (Washington, D.C., National Academy press (2001)

discussed in the context of common law systems. While they may differ in detail but these systems share the same basic approach. Reference is therefore made in some of the decisions of courts in the UK, the U.S.A., New Zealand, Australia, Canada, and India. Because errors and negligence raise issues of both civil and criminal liability and may also fall within the scope of professional discipline, we have taken all these jurisdiction into account.

The word negligence may be used in different ways because what is negligence in common parlance may fall short of negligence at law. In law, negligence and duty go together; the two are correlatives to each other.[6] For a surgeon to be negligent he must owe a duty to another. This means that in the absence of legal duty, there can be no negligence in the legal sense and no legal consequences too.[7] The law concerning negligence applies generally to everyone undertaking a daily routine within their usual endevours or employment.

In a strict legal sense, no distinction is drawn between the negligence of a doctor, plumber or window-cleaner. The general principles of tort law apply also to surgeons because of their profession which they hold out to be. The fundamental idea of the tort law is the existence of a duty of care. Most legal actions arising from the professional conduct of a surgeon in relation to his patient are brought based on the theory of negligence, which is a key concept of the tort law. These actions are often referred to as surgical negligence by nature of their job they carry out certain responsibilities that entail duties and liabilities.

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[6] Negligence is the omission to do something which a reasonable man guided by those considerations which ordinarily regulate the conduct of human affairs, would do; or doing something which a prudent and reasonable man would not do.

[7] Abraham, K S and Weiler, P C (1994) "Enterprise Liability and the Evolution of the American Health Care System" Harvard Law Review, Volume 108, Number 2, pp 381-436; Allen, T (1994) "Liability for References SPRING v GUARDIAN ASSURANCE" The Modern Law Review, Volume 57, Number 1, pp 111-116; Allen, T (1996) "Civil Liability for Sexual Exploitation in Professional Relationships" The Modern Law Review, Volume 59, Number 1, pp 56-77; Anon "Law Society to Improve Complaints Procedure" The Irish Times, 16 April 1996; Anon (1994) "Lawyers' Responsibilities and Lawyers' Responses" Harvard Law Review, Volume 107, Number 7, pp 1547-1674

Thus, medical malpractice, or surgical negligence, could be defined broadly as any unjustified act or omission of the surgeon or other related health care workers which results in harm either directly or indirectly to the patients.

A brief difference between surgical negligence and malpractice

Professional negligence and /or malpractice have the same connotation but the minor difference between them are more of such professional misconduct practices that a surgeon can engage into such as:

i) Advertising;
ii) Addiction;
iii) Abortion;
iv) Association and
v) Adultery[8].

Brief description of these five As: which come under medical malpractice

1. The Nigerian Medical council laid down a number Donts for the medical practitioners. These DONTS are made up of the list I have above. The council said, any medical practitioner found guilty of any of these offences as well as any other officially listed offences, is guilty of infamous conduct in a professional respect or, to use a simpler more recent terminology serious professional misconduct

Lord Justice Hopes[9] in 1894 explained what infamous conduct in a professional respect is, saying that if it is shown that a medical man in the pursuit of his profession, has done something; with regards to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competence then, it is open to the court to say he has been guilty of infamous conduct in a professional respect.

[8] Medical Law Report (PART 2), P.1 Vol. 1 Mach, 2015
[9] (1894) Lord Justice Hopes decision on infamous conduct in a professional respect.

A typical example of a case of malpractice is the case of ***Chairman, Medical and Dental Practitioners Investigating Panel Vs. Dr. Iroha Ukpola Iroha,*** [10] a registered medical practitioner, specialist obstetrician and gynaecologist, surgeon, and a medical director of Chironma Medical centre, located at No. 23 Adebola street, Surulere, Lagos. He attended to one Mrs. Nkoli Meka (now deceased) in his hospital on the 17th of May, 2003, in a most unprofessional manner. He carried out the surgery of hydrointubation (injection of a fluid through the neck of cervix of the womb into the fallopian tube) without the assistance of an anaesthetist, under general anaesthesia and with no suction machine. He carried out this operation at about 3:45 pm and went home and only came back by 6pm by invitation after the patient had died. Mrs. Virginia Nkoli Meka was only married for 9 months before.

She and the husband consulted Dr. Iroha and he sent the husband for semen analysis and found uterine fibroids in Mrs. Meka. He did not wait to see the result of the semen analysis he did to the husband before he proceeded to do the hydrointubation. The result of the semen analysis showed that the quality of the husband's sperm was below standard. Dr. Iroha saw this result after he had performed the hydrointubation, a procedure that led to her death. He did not offer credible explanation as to why he carried out the surgery without first waiting for the result of the semen analysis. He was found guilty by the Medical and Dental Disciplinary Tribunal and was suspended from practice for 3 months from the date of judgment. The judgment was upheld at the court of Appeal. The case of Dr. Iroha is typical case of both professional malpractice and negligence. He did not even sign a written consent.

Written consent is always necessary for all invasive operations. He claimed the patient died of anaphylactic shock on the death certificate. On the duty of an anaesthetist in post – operative

[10] (2015) 1 M.L.R. (Part 2) p.1

operation; the golden rule in anaesthesia is that the anaestetist's job is never completed until the patient has regained full consciousness. All properly designed operation theatres' environments have recovery rooms where patients are kept under trained and skillful observation until they regain their vital reflexes. The anaesthetist is always a few seconds away to deal with any problem(s). It is safe to send them to the wards only after they have regained consciousness but even there, they remain under the observation of trained surgical Nursing staff. The surgeons should always avoid being the general anaestetist, and a surgeon to the same patient at the same operation. They should remember that the post-operative period is the most dangerous stage of the procedure. Neglect during recovery period from general anaesthesia constitutes serious professional misconduct. The idea of some health institutions and surgeons deploying relatives to nurse their patients post – operatively is deprecate. It may save the institutions some expense in employing trained nurses but it could have deleterious effect on the standard of nursing care such a patient would receive. This will constitute serious malpractice to deploy unqualified and untrained nurse to nurse a patient recovering from a general anaesthesia. This type of malpractice must be avoided to save further loss of lives.

Another case to mention here is the case of Chairman of Medical and Dental Practitioners Investigating Panel Vs. Dr Emmanuel Emelumadu a registered medical practitioner, a specialist surgeon and medical Director of Setton Specialist Medical centre Awka, Anambra State[11]. The facts of the case is that the surgeon Dr. Emmanuel Emelumadu treated one Chief Nwokike who attended his hospital for the treatment of an ulcer on the lower part of his left leg. On 18th November 2001, the surgeon conducted an operation where he did a skin graft from the thigh to the ankle to quicken the healing. But it was reported that both the donor site and the main site did

[11] Charge No. MDPDT/26/2003, (2015) Med. M.L.R. 1 & 2 vol. 1 (part 11) P. 24

not heal rather got infected. This resulted in readmission of the patient (6) six weeks after discharge and discovered that the left leg had become gangrenous with sepsis.

Dr. Emmanuel could not refer this patient to a specialist who could have managed him better. The patient died and the children reported to the medical and Dental Practitioners Investigation panel. He was suspended for 3 months. The Tribunal made the following pronouncements to the surgeons that this tribunal is not going to tolerate Sloppy management of patients, and all doctors should recognize that, no matter how good they think they are they must not manage patients where there are insufficient facilities to give to patients better chances of survival.

The two cases above are typical examples of malpractice while the case I am describing below is a typical case of surgical negligence. ***Dr. Robert Olabode Akintade Vs. Chairman, MDPDT.***[12] The appellant, Dr. R. O. Akintade, (a surgeon), arraigned before the MDPDT for the following alleged offences:

(a) He failed to attend to the patient promptly;

(b) He manifested incompetence in the assessment of the patient by failing to diagnose her as a diabetic and failing to realise that the patient had a post-operative complication of faecal peritonitis (a hole or perforation of the intestine making faeces to escape from the intestine into the abdominal cavity, causing inflammation and infection of the peritoneum)

(c) He made glaringly avoidable mistakes in the course of treatment through inadequate history-taking, making inadequate pre-operative investigation, deficient operative procedure, and poor post-operative management.

[12] Suit No. CA/L/453/2001 (2015) 1 M.L.R. (part 2)at p. 100

In this case, he attended to one Florence Olusola Abe (deceased) at the Christian Health Centre Idomanasi, Ilesa, Nigeria, on the 27th October, 1997and 4th November, 1997 respectively, in a most negligent manner. She presented with acute appendicitis and rupture of the appendix. He was found guilty of gross negligence and malpractice infamously, in a professional respect contrary to applicable regulations[13] Being dissatisfied with the decision of the Tribunal, the appellant filed a Notice of Appeal dated 13th September, 2001 setting out his complaints on four grounds. The conviction of the appellant was affirmed on the 1st charge and he was suspended from practice for 3 months by M.I. Garba Justice, Court of Appeal. Above cases have been able to explain the difference between professional negligence and malpractice.

Therefore, surgeons and other healthcare providers are subject to a negligent rule of liability. Probably, since the beginning of medical practice, the society has taken cognisance of medical negligence as well. It is well-established under the law of negligence that medical practitioners owe a comprehensive duty of care to patients. The duty encompasses all aspects of their role and requires practitioners to take reasonable care in the provision of diagnosis, treatment, information and advice.[14]

Therefore, negligence in medical treatment is not different in law from negligence in any other field. The criteria and rules are the same, whether for liability, for causation or for compensation. Negligence in surgical operation or treatment always relates to a particular fact-situation, and what is decided in one case is usually of little help or may not help in deciding subsequent disputes. This is because it is also very hard to predict the outcome of the negligence

[13] Rules 10(a), (b)(c) and (d) of the Rules of Professional conduct for medical and Dental Practitioners in Nigeria (1990 edition) and punishable under section 16 of the Medical and Dental Practitioners Act, Cap 221, Laws of the Federation of Nigeria, (1990) as amended:

[14] Lord Bridge, *Medical Negligence*, (M.J. Powers and N.H. Harris, Butterworths, 1990) 1-6; D. Harris, *Medical Negligence: Compensation and Accountability*, (King's Fund Institute, 1988) p. 11.

in a particular case because of uncertainties surrounding the evidence and findings of fact,[15] and it is an exception to the principle of stare-decisis that says the ingredients of negligence are (i) duty of care owed in a particular situation by the medical practitioners to the plaintiff, (ii) failure to discharge the duty with reasonable care. Like cases must be treated alike and (iii) loss occasioned thereby to the patient and forseeable damage at the material time of the tortuous act and considered in law as the cause thereof[16].

It is claimed that negligence is negligence and jurisprudentially no distinction can be drawn between negligence under civil law and negligence under criminal law.[17] The quantum of damages generally incurred determines the extent of tortuous liability, however in criminal law, it is the extent of negligence that determines culpability.[18] In practice, it may happen that the patient suffers high damage but caused by small degree of negligence. This may not be sufficient for criminal prosecution of the surgeon.[19] However, a patient may suffer small damage but, the negligence may be gross. In this situation, the patient who suffered less damage may not likely seek criminal prosecution of the surgeon. The reason is that the patient is more grieved by the damage he/she has suffered rather than the degree of care or lack of it the surgeon has given. Either way, the degree of negligence in criminal law has to be higher than that of negligence enough to sustain liability for damages in civil law.

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[15] A. Simanowitz, "No Fault Compensation: Short Term Panacea or Long Term Goal?" In *No Fault Compensation in Medicine*, R.D. Mann and J.D. Havard, ed. (Royal Society of Medicine, 1989) 151.

[16] M. A. Jones, *Medical Negligence*, (Sweet and Maxwell, 1991) p. 3; Sheila A.m. Mclean, *A Patient's Right to Know*, (Dartmouth Publishing, 1989) 26.

[17] Generally J.K. Mason and R.A. McCall Smith, *Law and Medical Ethics*, (3rd ed. Butterworths, 1991) Chapter 6 and16.

[18]Cooray, Anton.' Toward More Efficient Administration: Citizen's Charter in the United Kingdom and Hong Kong's Performance Pledge' (1993) 2 *Hong Kong Public Administration*, 159-76.

[19]Huque, A.S., Tao Lai, P.W. and Wilding P, *Understanding Hong Kong*, in P. Wilding, A.S. Huque and P.W. Tao Lai (eds), *Social Policy in Hong Kong* (Edward Elgar, United Kingdom 1997).

With regard to professionals, in determining what constitutes reasonable care, the court takes their training and expertise into account.[20] Therefore, if a professional violates his or her responsibility towards a client, the client may bring a suit against the professional, alleging negligence, which is essentially professional negligence.[21] Except in a case of *res ipsa loquitor*, which literally means the thing speaks for itself, the onus is upon the plaintiff to prove negligence on a preponderance of probabilities. Otherwise, the entire claim will fail. Therefore, the surgeon and health care providers must exercise special caution and diligence in the management of patients.[22]

In every day conversation, the word negligence is invariably and synonymously used with carelessness. The accusation of negligence may be applied to any conduct that falls short of the standard expected of a person whom a duty of care is owed and which causes foreseeable damage to that person.[23] In a legal context, it is important to note that negligence has a specific and concrete meaning. It must be established that there exists, a duty of care in favour of the plaintiff against the defendant and that there has been a breach of that duty by the defendant. It is only then that the plaintiff can claim that the injuries or loss (damage) suffered are a result of the defendant's actions either directly or as part of a transaction. For a example the case of ***Lochgelly Iron and Coal Co. vs. M. Mullan per Dillon***,[24] L.J said that it is now elementary that

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[20] R.S. Emerson and R.M. Schwartz, "Professional Liability", *New York State Journal of Medicine*, 1983, 69 at pp. 71 74.

[21] See Lord Edmund-Davies' opinion in *Whitehouse v. Jordan*, [1981] 1 All E. R. 267, at p. 276: ".While some errors may be completely consistent with the due exercise of professional skill other acts or omissions in the course of exercising "clinical judgment" may be glaringly below ,proper standards as to make a finding of negligence inevitable."

[22]T Thirumoorthy, (2006), "Understanding the Basis of Medical Negligence" *June Medical Grapevine* 30.

[23] Cheung A, 'Medical and Health', in D.H. McMillen and S.W. Man (eds) *The Other Hong Kong Report 1994* (The Chinese University Press, Hong Kong 1994) 351-65.

[24]*Lochgelly Iron and Coal Co. v M' Mullan* [1934] AC1, 28. See also the following cases: *F v R* (1983) 33 SASR 189, 192 ff (King CJ), affd *Rogers v Whitaker* (1992) 175 CLR 479, 488, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See, eg, *Rosenberg v Percival* (2001) 205 CLR 434; *KL v Farnsworth* [2002] NSWSC 382; *Henderson v Low* [2001] QSC 496; *Johnson v Biggs* [2000] NSWCA 338; see generally, Thomas Addison, 'Negligent Failure to Inform: Developments in the Law since *Rogers v*

the tort of negligence involves three factors; a duty of care, breach of that duty and consequent damage. When surgical negligence occurs, legal action may be taken to protect the victims and prevent recurrence of the event.[25] The reason for actions against surgical negligence is explained by Margaret Brazier when she said that[26] the patient may feel that he has not been fully consulted or properly counseled about the nature and risks of the treatment. He may have agreed to treatment and ended up worse, not better. Consequently a patient may seek compensation from the courts. Or he may simply want an investigation of what went wrong, and to ensure that his experience is not suffered by others.

Therefore, it can be said that health care workers play a very important role in everyone's life. Undoubtedly, ensuring the accountability of medical professionals is a matter of concern for every society. In Nigeria, people usually have a high expectation of the medical health care system because the society is relatively developing and the awareness of rights is becoming a bit high. Against the above backdrop, this thesis aims at investigating the concept of surgical negligence. It is intended to analyse the legal framework on surgical negligence and make recommendations for improvement.

1.2.0 STATEMENT OF THE PROBLEM

With the growing incidence of surgical negligence in Nigeria, numerous cases are being instituted in court against surgeons for surgical negligence. This is coupled with the awareness of medical negligence due to the improved education of the populace as well as the increasingly easy access to medical information. However, negligence by surgeons is hard to determine by

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Whitaker' (2003) 11 *Torts Law Journal* 165, 167–80.

[25] See Bogner, Marilyn *Human Error in Medicine.* (Lawrence Erlbaum Associates Publishers, New Jersey 1994).

[26] See Brazier M., *Medicine, Patients and the Law*, (Harmondsworth, Penguin 1987), particularly at p.5, where she notes 'Few professions stand so high in general public esteem as that of medicine. Yet few individuals attract greater public odium than the doctor or nurse who falls from the pedestal.'

judges as they are not skilled in medical science. Many studies have shown that alternative dispute resolution is often an effective tool for resolving civil cases except criminal cases. In fact, in some jurisdictions, settlement of surgical negligence claims by means of alternative dispute resolution is encouraged. Nonetheless, whether it is by litigation or by settlement out of court, there must be some standards to determine the extent of liability. Since it is neither possible for the law nor for a judge to foresee all circumstances when a surgeon, as argued earlier on, could be held liable due to the fact that each case of surgical negligence is unique on its own. It is desirable that every case must be decided on its own merit. This has posed a great challenge to a judge in deciding cases of surgical negligence. Because there have been complaints here and there of surgical negligence pertaining to surgeons, so, there is the need to ascertain the veracity or otherwise of such claims regarding the overall performance of surgeons.

In view of the above, the research questions for the study are as follows:

i) What is negligence and what does medical negligence connote?

ii) How cordial is the interrelationship binding the surgeon and his surgical patient?

iii) When does liability against a surgeon arise?

iv) What are the remedies available to a victim of surgical negligence?

v) What are the major rights of a surgical patient and how effective are the laws regulating surgical practice in Nigeria?

1.3.0. AIM AND OBJECTIVES

The Broad aim of this study is to analyse The Legal Rights of Surgical Patients on the Duties and Liabilities of surgeons in Nigeria. Other specific objectives are:

(a) To analyse the legal implications of the breach of duty by surgeons on surgical patients particularly as it relates to liabilities under civil and criminal law.

(b) Examine the judicial attitude towards the rights of surgical patients in surgical negligence.

(c) Assess the qualification and expertise of surgeons.

(d) Asses the performance of surgeons in the discharge of their legal obligations. and

(e) To examine the adequacy of the legal frame work on the liabilities of surgeons and to Identify factors militating against the full application of laws relating to surgical negligence in Nigeria.

1.4.0. FOCUS OF THE STUDY

Although there are wide areas of tort of negligence, this study will not cover all the areas of tort of negligence. Rather, it will only focus on the rights of patients *vis-a-vis* the duties of surgeons and the instances when the breach of duty may constitute surgical negligence and the available remedies. This thesis does not intend to alter the basic principles of tort law which laid down the foundation for judgment of surgical negligence; rather, it will critically evaluate nature of liabilities of surgeons in Nigeria.

1.5.0 SCOPE AND LIMITATION OF THE STUDY

The issue of medical negligence is a global phenomenon. However, for the sake of this thesis, the study will be limited to Nigeria using four hospitals as case study. Though reference may be made to other jurisdictions in order to see what Nigeria stands to gain from the practices of such jurisdictions since this thesis is not comparative in nature. The researcher was limited by time because she needed to collect the responses in order to finish the thesis in time. The researcher was also limited by fund because to produce the questionnaires to cover the number of respondents as well as travelling several times to the different locations of the study was not easy.

The researcher was also limited by the fact that the respondents did not fill the questionnaires early. Some of the information supplied in the questionnaires were also not reliable thereby reducing the data for analysis. There was also initial unwillingness on the surgeons to cooperate with the filling of the questionnaires. This accounted for a reasonable delay in filling and collection of the questionnaires.

1.6.0 RESEARCH METHODOLOGY

The study adopted research design for the collection of data, through the qualitative and quantitative method of legal research. The research involved the assessment of Legal Rights of Surgical Patients on the duties and Liabilities of surgeons.

Data for the study was collected from surgeons, surgical patients and surgical nurses in four different hospitals located at different parts of Nigeria. Data for the study was collected using stratified random sampling method. It was decided before hand that data would be collected from the surgeons, surgical patients and surgical nurses, thereafter, random sampling technique was employed.

Sources of data:

Data for the study was collected from two sources – primary sources and secondary sources.

The primary sources involved the design of the questionnaires having three sections – section one for the surgeons, section two for surgical patients while section three is for the surgical nurses. The questionnaires were administered on the respondents by the researcher and agent of the researcher who helped to distribute and collected the questionnaires. Personal interviews were held with some of the respondents who were randomly chosen. The purpose of the interview was to increase the validity and reliability of the information supplied on the questionnaires.

Secondary sources

Data and information for the study were collected through secondary sources which include: Case laws, Law journals, books, internet, reports of meetings from the various hospitals, newspaper reports, reports from non-governmental organizations, thesis and so on.

The data collected was analysed using Percentages and Frequency Distribution Method.

1.7.0 LITERATURE REVIEW

There are many writings on medical negligence worldwide and in Nigeria. Some authors have written on the meaning of negligence or what negligence entails. For instance, Winfield has defined negligence as a tort which is a violation of a legal duty to take care which results in damage, undesired by the defendant to the plaintiff. An act involving the above ingredients is a negligent act.[27] Baron Alderson defines negligence In Re ***Blyth***[28] as an omission to do something which a reasonable man would do, being guided by considerations of normal human affairs, or doing something which prudent and reasonable man would not do. Charles Worth[29] modifies Alderson's definition and defines negligence as a tort which involves a person's breach of duty that is imposed upon him to take care; resulting in damage to the complainant. Furthermore, J.S Colyer[30] points out that the word negligence may be used in two senses. First, it is the name of a tort where the injured brings a suit against the wrong-doer for damages. Secondly, negligence itself is sometime ingredient of other torts. Negligence, therefore, is a tort as well as a concept of the law of torts. Also, Austin and Salmond[31] argue that negligence is a state of mind, not a conduct. To them, negligence is a mental condition which should be penalised by damages. However, a commentator criticises the Austin's concept of negligence as criminalist type of

[27] Winfield and Jolowizc, *Tort*, 5th , p.4.
[28] *Blyth* v. *Birmingham Water Works Company*, (1856) ll Ex 781.
[29] Charlesrworth& Percy, *Negligence*, 19th ed. p. l6.
[30] Colyer JS, A Modern View of the Law of Torts, (1st edition Pergamon Press, London, 1966) 36.
[31] Fitzgerald P J, Salmond on Jurisprudence, London: Sweet and Maxwell 1963, 12th edition, 1967, at 390.

negligence. The writings of these authors are very useful to this thesis in that they have been able to give a working definition to the concept of negligence and further provide guiding principles to be able to identify when negligence arises. However, the authors did not examine negligence as it affects medical practitioners or surgeons.

Kennedy Ian and Grubb[32] wrote on medical negligence of the doctors with special reference to the surgeons and other healthcare professionals. Their writings center on the need for the surgeon to seek express consent of the patient in conducting surgery and to inform the patient of the risks of the surgery or treatment he/she is to undergo. They argue further that the essence of this is to put the doctor on a defensive side and where any harm or injury occurs due to the failure to obtain consent, he would be liable in negligence. This is similar to the view of Evans Tudor J[33], in his writings on medical negligence. He however added that in cases of emergencies especially if the patient is unconscious, seeking the consent of a patient might prove impossible. Similarly, Mclean Sheila[34] shares more on this when he argued that informed consent is an integral part of surgical practices failure of which would make the doctor liable in surgical negligence. He based his argument on the fact that every patient has a right to know what is to be done to his or her body. The works of these authors are very crucial to this thesis to the extent that they have been able to provide an insight as to what medical negligence connotes and the roles of a medical doctor to a patient. However, they did not examine the extent of liability of a surgeon.

Devereux John[35], discusses the importance of doctor/patient relationship as it relates to professional negligence in terms of legal obligation in the delivery of healthcare. The author

[32] Kennedy & Grubb: Medical Law; Texts with Materials, U.S. Btterworths, Publishers, 2nd ed., 1974.
[33] Evans T.: Informed Consent (Medical Negligence), Oxford. London, Oxford University Press, 2001
[34]
[35] Devereux on Medical Negligence, London, Oxford University Press, 2001

argued that one of the most important aspects of doctor-patient relationship is the duty to take reasonable care. That is, the duty of a surgeon is to exercise caution in the treatment of his or her patient. According to the author, an action for medical negligence would arise where the surgeon has failed to exercise reasonable care as required by law.

Hendrick Judith's[36] work centers more on the importance of awarding compensation to the victims of medical negligence. The writer argued that there are two reasons for the award of compensation against a professional for surgical negligence. The first is to minimise the impacts such negligence might have on the victim and the second is to serve as deterrence in order to reduce both the number and seriousness of medical accidents by making professionals personally liable. He argued further that threat or fear of legal action and the potential damage to professional reputation would ensure that greater care is taken in the treatment of patients.

Herring Jonathan[37] dwells on the elements of medical negligence which pertains to the duty of care owed to the patient, the default in the exercise of that duty resulting to damages. It was a further submission of the author that whether or whether not a duty is breached depends on the facts of each case. The contention was based on the fact that doctors are meant to make patients better, not worse. The author opines that where there is connections between the wrongful act of the doctor and the resulting injury to the victim, the act would be deemed as the cause of the injury.

Similarly, Barrett[38] on medical negligence argues that action for medical negligence could be brought either under the tort of negligence for personal injury or on breach of statutory duty. He posits that to succeed in an action for medical negligence, the plaintiff has the burden of proving the existence of a duty of care owed to him by the defendant, that the duty was breached

[36] Hendricks: Legal Aspects of Child Healthcare London, Chapman and Hall Company, (1997)
[37] Herring Jonathan: Medical Law Express, Birmingham, U.K., Pearson Ltd, 2011.3rd edition
[38] Barrett, The Head Nurse, London, Meredith Corporation Publishing Company by Appleton Century, Crofts, 1975.

by the latter's wrongful act, which caused actionable damage to him/her. He concluded by noting that whether the defendant is liable for breach of statutory duty or not depends on the circumstances of each case. The works of these authors are very useful to this thesis because they have been able to provide a background study into what constitutes surgical negligence and what is required of a victim claiming for damages. However, they did not discuss the liability of a surgeon and remedies open to the victims.

McCarthy[39] wrote on criminality of surgical negligence. The work argues that where the level injury caused to a patient is high; such a doctor should be prosecuted under criminal law. The author states that where a medical practitioner has taken a substantial risk with the patient's safety or wellbeing, the award of compensation for negligence will not suffice. On this note, he concluded that judges should evaluate a practitioner's conduct to decide if the behaviour demonstrates criminal misconduct causing significant danger to the physical or mental wellbeing of the patient. Similarly, Jackson[40] wrote on instances where a surgeon may be liable for criminal prosecution. He argued that where a patient dies as a result of negligent conduct, the most likely criminal charge would be manslaughter for gross negligence and that a doctor who operates on a patient without his/her consent could possibly face a charge of criminal battery. Surgeons are very conscious of the risk of being sued and tend to overestimate the risk. A large number of surgeons believe that being sued will adversely affect their professional, financial and emotional status. On this note, the Office of Technology Assessment, U.S. Congress argues extensively in favour of defensive medicine.[41] Defensive medicine occurs when doctors order tests, procedures, or visits, or avoids certain high-risk patients or procedures, primarily (but not necessarily solely)

[39] McCarthy: Malpractice, On Advance for Nurses, http//nursingsadvanceweb.com//continuing/CE, Articles.
[40] Jackson M, Medical Malpractice, Texts, Cases and Materials, London, Oxford University Press, 1994
[41] U.S. Congress, Office of Technology Assessment, *Defensive Medicine and Medical Malpractice, OTA-H--6O2* (Washington, DC: U.S. Government Printing Office, July 1994) 2-6.

because of concern about negligence liability. The Writer argued that medical practitioners' concerns about liability drive those surgeons to order series of tests, and procedures in order to avoid the possibility of being sued. This book is very relevant to this thesis to the extent that it pictures the various ways by which surgical practitioners could avoid surgical negligence by the adoption of defensive medicine. However, the book does not analyse liabilities of medical practitioners.

Furthermore, Peter P., Budetti, M.D., Edward E. and Helen T. Bartlett[42] examined specifically, medical negligence law in the United States. The Writers argue in favour of the need for statute to regulate surgical negligence. The authors noted that prior to the Tort Reforms Act; cases of surgical negligence are being decided upon rules formulated by judges on basis of tort of negligence. The authors view point is that putting in place an enabling law to regulate medical practice will assist the judge to evaluate the adequacy of care, how much money the plaintiff should be paid, how the damages should be paid and by whom. These are, according to the authors, questions that judges have found difficult to come up with guiding principles.

Also, KNT Dayarathna[43] discussed the various ways by which medical negligence may occur. The Writer argued that medical negligence may occur if the doctor failed to disclose necessary information to the patients so that the patient may make a voluntary choice to accept or refuse treatment. The paper is relevant to this thesis because the author was able to disclose the various means by which medical negligence may arise. However, the paper is limited in scope to Nigeria.

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[42] Peter P., Budetti, M.D., Edward E. and Helen T. Bartlett, *Medical Practice Law in the United States* (University of Oklahoma Health Sciences Center, 2005) 3-7

[43] KNT Dayarathna, "Medical Negligence Law; for a Better Approach in Sri Lanka" *Proceedings of 8th International Research Conference, KDU, 2015*

Some authors have written from the perspective of compensation available to victims of medical negligence and liabilities of surgical practitioners. For instance, L. C. Coetzee and Pieter Carstens[44] wrote on surgical negligence and compensation in South Africa. On this note, the authors argued that liability for professional medical negligence is primarily founded upon the Law of Obligations. In this regards, all compensation for medical negligence (including medical error and any adverse event) should be based on fault and assessed with reference to the measure of the reasonable expert in the same circumstances. The authors concluded that the generic test for negligence is thus one of foreseeability and preventability.

Similarly, B.D. Gupta[45] wrote on medical liability both in civil and criminal law. The author argued that it is the quantum of damages inflicted that governs the extent of tortious liability; However in criminal law it is the extent of negligence that is determinative of liability. In the same vein, Patricia M. Danzon[46], wrote on liability for medical negligence.

The Writer argued that if the sole function of liability is to provide compensation, it is extremely inefficient. According to him, torts benefits are unpredictable and therefore provide poor insurance to the victim. On this note, the author concluded that appropriate policy for insurance scheme should be put in place to further ensure safety of patients and mitigate liability of a surgeon. Furthermore, Tracey Carver and Malcolm K Smith[47] wrote on medical negligence,

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[44] L. C. Coetzee and Pieter Carstens, (2011) "Medical Malpractice and Compensation in South Africa" 86(3) *Chicago-Kent Law Review,*

[45] Gupta B.D., (2005) "Medical Negligence: Civil Vs Criminal; Issue Settles" *JPAFMAT,*.

[46] Patricia M. Danzon, (1991) "Liability for Medical Malpractice" 5(3) *Journal of Economic Perspective,*

[47] Tracey Carver and Malcolm K Smith, "Medical Negligence, Causation and Liability for Non-Disclosure of Risk: A Post-*Wallace* Framework and Critique" (2014) 37(3) *UNSW Law Journal,* 972-977. For more on liability of medical practitioner, see the following cases: *F v R* (1983) 33 SASR 189, 192 ff (King CJ), affd*Rogers v Whitaker* (1992) 175 CLR 479, 488, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See, eg, *Rosenberg v Percival* (2001) 205 CLR 434; *KL v Farnsworth* [2002] NSWSC 382; *Henderson v Low* [2001] QSC 496; *Johnson v Biggs* [2000] NSWCA 338;; Thomas Addison, 'Negligent Failure to Inform: Developments in the Law since *Rogers vWhitaker*' (2003) 11 *Torts Law Journal* 165, 167–80

causation and liability. The authors argued that for medical practitioner to be liable for negligence; there must be a nexus between the act of the doctor and injury caused to the victim.

The Writers went further to add that a finding of causation commonly hinges upon the patient establishing that, if the practitioner had been mindful of the duty of care owed, the patient would not have suffered injury in the form of the physical manifestation of relevant risks inherent in the procedure. This means that causation arises in the context of assigning legal responsibility for a particular act or omission which requires a determination of whether a defendant's conduct played a role in bringing about the harm that is the subject of the claimant's negligent action. In a comparative study conducted by the Law Library of Congress on medical negligence in Canada, England and Wales, Germany and India,[48] the Congress defined medical negligence claims as typically tort claims brought against an individual physician for negligence, or claims brought against a medical institution under the principle of vicarious liability depending on the nature of the case. In this regard, the Congress stated that it is necessary to put in place a medical liability insurance policy in order to lessen the burden of a medical practitioner in negligence.

Still on medical liability, Anurag K. Agarwal[49] argued that liability of a medical doctor or a surgeon cannot be determined by the judge without scientific proof which can only be provided by an expert since judges are not well grounded in science. Kenneth McK Norrie[50] wrote on medical negligence on the determination of the question who sets the standard? To the author, medical negligence is similar to all other aspects of negligence which has to do with the determination of whether the defendant came up to the extent of care which he owes the plaintiff

[48]The Law Library of Congress, *Medical Liability: Canada, England and Wales, Germany, and India,* (The Law Library of Congress, Global Legal Research Center, U.S, 2011)
[49] Anurag K. Agarwal, (2011) *Medical Negligence: Law and Interpretation,* (INDIAN INSTITUTE OF MANAGEMENT, India, 1-4
[50] Kenneth McK Norrie, "Medical negligence: who sets the standard?" (1985) 11 *Journal of medical ethics,*

and whether the surgeon has reached the level of expected care. On this note, the writer argued that cases of medical negligence are a little unlike the usual case, particularly bearing in mind the standard of care required of individual doctors. In the usual case, the court is wholly capable to lay down what the reasonable man should do in daily circumstances because judges understand and are aware of everyday circumstances.

However, in the case of surgical negligence, judges have no great level of understanding to be able to determine the reasonableness of medical practice. According to the author, this is due to the fact that the details of medical science are not generally within judicial competence and knowledge and as such cases of medical negligence should not be left to the courts to lay down the standard to be attained. The author concluded that the law should indeed have regard to commonly accepted medical practices in determining whether what a particular doctor did was or was not negligent. The paper of these authors is of importance because they have been able to provide guiding principles on how to establish liability of medical practitioner for negligence. However, the authors did not examine the issue of how to measure such liability and none of the authors analysed the criminal aspect of liability of medical practitioners. Also, none of the authors examined the perspective in Nigeria which is the focus of this study.

Kennedy & Grubb[51] identified and commented on the discrepancy between medical autonomy and judicial decision making. The authors also explain that in a subtle way, courts have empowered the medical profession to both determine what standard of care should be and whether it has been contravened in specific instances in a particular case. But Kennedy and Grubb pointed out the judgment of what is reasonable should not be made by the doctor and unanimously approved practice is not necessarily reasonable. In Kennedy & Grubb's view, therefore, adherence to a standard accepted practice is not conclusive as to the reasonableness of

[51] Kennedy, I & Grubb, (1994) .A *Medical Law: Texts and Materials*, 2nd Edition, (London, Butterworth)

the practice. Hence, a doctor can still be held negligent if he adhered to an accepted practice that the court considered unreasonable. To the authors, the court should distinguish between what is ordinarily done and what ought to be done, taking into account the interest of the plaintiff and of society at large. This line of thought is supported by Montrose[52]. Montrose believed that negligence is about what ought to have been done by the defendant. This view is shared by Stally Brass, stated that the general practice itself may not conform to the extent of care expected from a rightful thinking man. In such instance, it was posited that it is not a good defence that the defendant has acted with general practice.

Jones agreed with Stally Brass on this point. He asserted that this is the true interpretation of the decision in ***HUNTER v HANLEY***[53]where Lord Clyder referred to the reasonable competent man to mean what ought to be done by reference to a reasonable doctor. At this juncture, it is now pertinent to examine literatures from Nigeria to further justify the present study. To start with, J.A Dada,[54] examined the legal aspects of medical practice in Nigeria. He argued that a medical practitioner owes a duty to exercise reasonable skill and care in the treatment of his patients. The author went further to add that this duty exists independent of any contract. So, if there is a breach, the Medical Practitioner will be held liable irrespective of the fact that there was no contract. Similarly, B.C Umerah[55] wrote on the relationship between patient and doctor. The author noted that once a doctor undertakes to treat a patient, whether or not there is an agreement between them, a duty of care arises. Also, Eric Okojie[56], examined professional medical negligence in Nigeria. The Writer argued that there is the need for patients to be

[52] Montrose .A (1958) "Is Negligence an Ethical Sociological Concept" *The Modern Law Review*, Volume 21, Number 3, pp 259-264
[53] Jones M.A. (1994) "Tort" Current *Legal Problems*, Volume 47, Oxford University Press.
[54] Dada J.A., (2002) Legal aspects of Medical Practice in Nigeria, Pg 89
[55] Umerah B.C., (1989) Medical Practice and the Law in Nigeria, Pg 123
[56] Eric Okojie, "Professional Medical Negligence in Nigeria" retrieved from http://www.nigerianlawguru.com/articles/torts/PROFESSIONAL%20MEDICAL%20NEGLIGENCE%20IN%20NIGERIA.pdf [accessed on the 20th March 2016].

protected from medical practitioners who no longer see their roles as that of saving lives but as that of making money. The writer went further to add that the responsibility of a medical practitioner towards a patient commences as soon as the medical practitioner secures the consent of a patient to undertake a medical examination and that such consent must never be presumed.

Furthermore, Dennis Uba Donald[57] writes on the curious case of negligence in Nigeria. His focus was on the side effects of negligence on a patient. On this note, the author was of the view that 80 percent of cases of medical negligence involved death or serious injury to innocent patients thereby bringing untold grief to families or sometimes leaving patients in a worse situation than they were before they came to the hospital for treatment. From empirical perspective, Ushie, Salami, Jegede & Oyetunde[58] recently conducted a study on the reaction of patients to medical errors in the University of Calabar Teaching Hospital. Their findings revealed that majority (64.5%) of respondents reported annoyance and disappointment with medical errors while a larger percentage as well expressed intention to litigate medical negligence.

This work is relevant to this thesis in that it shows that issue of medical negligence is considered serious among Nigerians. In a similar vein, studies have shown that majority of adverse incidents occurring in healthcare delivery are preventable mistakes. It is on this premise that Akintola[59] argued that failure to take medical history by a surgeon to enable him effectively treat and/or detect ailment of a patient is very inimical and thus activate the patient's rights to sue for negligence. He concluded with the expression that if a doctor fails to take such history, he

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[57] Dennis Uba Donald, (2014) "The Curious case of Negligence in Nigeria" 2(1) *The International Journal of Indian Psychology*,

[58] Ushie, B.A., Salami, K. K., Jegede, A. S.,& Oyetunde, M. "Patients' Knowledge And Perceived Reactions To Medical Errors In A Tertiary Health Facility In Nigeria" (2013) 13(3) *African Health Sciences,*

[59] Akintola, S.O., (2002) "Medical Negligence in Nigeria: An Appraisal" Volume 1*University of Ado-Ekiti Law Journal, 35-46*

will be liable in negligence. In addition, Jadesola O. Lokulo-Sodipe[60] focused on elementary rights of a patient. Rights of a surgical patients forms the fulcrum of this work. The rights of surgical patients within the purview of domestic and international human rights laws.[61]

The author argued that rights, such as the right to life, human dignity, personal liberty and to give consent are basic rights enjoyable by a patient; the denial of which entitles such a patient seek remedy for the violation of his or her rights. This paper is very relevant to this thesis because it gives an insight into the basic rights of patients. This is for the obvious reason that these rights are derived from the duties of medical practitioner. However, the author did not examine liabilities of medical practitioners for the violation of the legal rights of patients. Similarly, Omole O. Iyayi, Rawlings O. Igbinomwanhia and Festus Iyayi[62] focused their discussion on classification of mistakes in patient care in a Nigerian hospital. The authors argued that classifying mistakes and errors in patient care have major implications when mistakes are managed and the degree to which the management of such errors lead to learning for the individuals and groups in the health institution. The writers argued further that classifying clinical mistakes is crucial in order to know the appropriate mechanism for resolution. In this perspective, mistake refers to an action or opinion that is not correct, or that produces a result that a person did not want. The works of these authors are relevant to this thesis because they have been able to provide a background study into medical negligence and how it may arise.

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[60] Jadesola O. Lokulo-Sodipe, (2009) "An examination of the legal rights of surgical patients under the Nigerian laws" Vol. 1(4), *Journal of Law and Conflict Resolution*, 079-087

[61] The natural law school for instance regards human rights as those conferred by God. This school of thoughts further argues that human or made-made laws must conform to it in order to be valid. But due to reformation and the decline of the role played by the Church in the state affairs, there came the positivists who secularized the notion of human rights; they thereby removed the issue from the realm of supernatural and metaphysics. However, human rights are defined as those which have become part of a positive legal system derived either from the will of a state or command of the sovereign ruler. For more detail view see Barau "Towards Effective Promotion and Protection of Human Rights in Northern Nigeria" in Yemi Osinbajo, *et al* (eds) *Human Rights, Democracy & Development in Nigeria* (1995-1996) 313 at pp. 314-315.

[62] Omole O. Iyayi, Rawlings O. Igbinomwanhia and Festus Iyayi, (2013) "Classification of Mistakes in Patient Care in a Nigerian Hospital" 13(3)*Global Journal of Medical research Interdisciplinary*,35-38

However, they have not been able to undergo a detailed research into how to determine and measure liability of a medical practitioner. Also, none of the papers has discussed institutional frameworks regulating medical practice in Nigeria as this is an alternative means by which an aggrieved person may ventilate his or her grievances.

The exploration of the existing literatures available on this study shows that the issue of medical negligence has been addressed by authors, international institutions and non-governmental organisations. This actually reveals that the medical practitioners must be cautious while treating their patients as there is nothing wrong for a patient to sue for medical negligence. However, most of the available literatures are general discussions on the surgical of negligence and surgical negligence. In fact, those that appear to be specific in nature only limited their scope to other jurisdictions and not directly related to Nigeria. More so, the available literatures on Nigeria have not sufficiently addressed the question of how to measure or determine surgical negligence. Thus, most of these omissions or gaps will be addressed in the course of this research. It is expected that this research will improve on the existing literatures and offer some guidelines for future reference.

1.8.0. DEFINITION OF TERMS

Quite a number of terms have been employed in the course of writing this thesis. Among those terms and their usage in the study are:

Doctor or a medical practitioner: this refers to a surgeon in this thesis.

Surgeon: In this study, a surgeon is used synonymously as the Doctors in the hospital

Legal Analysis: This is used as an examination of laws in relation to medical negligence in Nigeria.

Patients: Patients in this study are those that seek for medical treatment from a surgeon in conventional hospitals.

Professionals: In this study, professionals refer to those with expertise or knowledge in conventional surgical practice.

Legal right: these are rights by the common law court as distinct from equitable right. In this study legal rights are refer to surgical patients' rights.

1.9.0 CONCLUSION

This chapter has been able to provide a background study to this research and the aims and objectives of the study have been clearly stated. Also, the methodology for carrying out of this research has been identified. As clearly stated, the study is limited in scope to professional negligence of surgeons in Nigeria. Furthermore, the available literatures were reviewed in order to identify the existing gaps and to justify the present study.

CHAPTER TWO

ANALYSIS OF SOME MAJOR CONCEPTS

2.0.0 INTRODUCTION

This chapter examines some major concepts within the objectives of this thesis. The chapter begins by examining the doctrine of negligence. This is expedient in order to delineate the meaning of this concept within the aim and objectives of this thesis. The thesis also examines professional doctrine since this thesis is all about liability of professionalism. Also, the thesis will examine the meaning of surgical negligence. This is fundamental since determining the liability of medical practitioner, which includes the surgeon, is the basis of this thesis.

The thesis further examines how surgical negligence could be proved. This is desirable in view of the fact that damages would not be awarded without proving some fundamental rules such as the existence of the duty of care, the breach of that duty and resulting damage. In addition, the thesis examined the issue of causation. This is important to the effect that for negligence to be established there must exist a link between the action of the respondent and the injury caused to the claimant. In addition, this thesis examines the evolution of medical practice vis-à-vis the surgeons. Before discussing the concepts in this chapter, the thesis would want to have the knowledge of the historical evolution of medical practice vis-à-vis the surgeons, and the origin of surgical malpractice litigation globally, to be able to give the overview of the history and evolution of surgical practice, surgeons and origin of surgical negligence.

2.1.0. Historical Evolution of Medical Practice vis-à-vis surgeons

Medical practice dates back to as far back as the 1511, 4th Century B.C. under the title of Hippocratic corpus. This first Medical Act of 1511 provided that none should practice physics or surgery (except graduates of Oxford or Cambridge) unless licensed by the Bishop of his Diocese. Before a license was granted the candidate was to be examined and approved by an expert panel summoned for the purpose by the Bishop. A continuing penalty of £5 per month was laid down for unlicensed practice. An amending Act was passed in 1542 exempting from the penalties for unlicensed practice divers honest persons with the knowledge of the nature, kind and operation of certain herbs, roots and water and the using and ministering of them to such as be pained with customable disease[63] The exemption could be claimed only by those who practiced without fee. (College of Physicians vs. Butler, 6 Charles 1)[64]. The first of medical practice was under the control of the Catholic Church, since at that time the Catholic Church was the only – Corporate Body with the necessary organizational skills to administer the Act. The establishment and growth of the several medical societies provided alternative means of licensing persons to practice medicine. The College of Physicians was founded by Royal Charter in 1518[65].

Its functions, exercised in and for seven miles around London, were to grant licenses to those qualified to practice, to punish pretenders to medicine and also those who committed malpractice, whether by license or unlicensed persons. An act of 1540 established the United Company of Barber- Surgeons, bringing together the companies of Barbers, who performed minor surgery, and of surgeons into a single company. An act for the dissolution of the United Company, promoted by the surgeons, was passed in 1745 and in 1800 the College of Surgeons

[63] An amending Act 1542 exemption from the penalties for unlicensed practice
[64] College of physicians vs. Butler, 6 Charles (1st medical practice in the hand of Ecclesiastical authorities
[65] College of physicians was founded by Royal Charter in 15 18

was formed. The eventual disappearance of the ecclesiastical authorities from the sphere of medical control, the conflicts and jealousies of the various licensing bodies and their efforts to safeguard ancient privileges and secure for their members rights of practice, are now of historical interest only.

Ever since then, the medical practice has witnessed systematic and geometrical growth and it has for a long time been regulated by the statutes of the profession. And to ensure professional competence, formal training in approved institutions is now a *sine qua non* for persons seeking to be admitted into the medical profession. It must be noted here that before the advent of a science – oriented and regulated practice, the area of medicine was covered by traditional medicine men[66] who are known to be practitioners of the art of traditional medicine. They were also taken to be mystic in a primitive culture dealing with multifarious and multi – dimensional ailments and medical conditions. They were known as (Father of all diseases). This can be explained why medical practice is not exclusive to only trained hands (conventionally trained). This is because in Nigeria today traditional medicine is on the increase called trado-medicalism and is thriving even more that the orthodox medical practice. There are in different shades and descriptions, the medical quacks, the homeopaths who parade themselves all over the country under all sorts of dubious titles.

The recent catch of a medical quack, reported in Punch Newspapers on Tuesday, 22nd June, 2016, was one Celestine Yolofun, aged 32 years. It was reported that he dropped out of a Nursing school in Benin Republic and came down to Apapa area of Lagos State to practice in his so-called hospital, as a doctor for 11 years from 2005 to 2016 before his arrest by the Lagos state

[66] A.Ekong Bassey, (1997) the legal Aspects of medical practice Calabar Abjere onward publications, p. 1

Criminal Intelligence and Investigation Panel[67] The problem of quacks in Nigeria is enormous. For example, drugs under Dangerous Drugs Act and other scheduled drugs are being dispensed all over the streets in Nigeria. Most unqualified persons also run fake clinics or hospitals which are clearly beyond their capabilities. This process is a serious health problem to the populace. Hence, it is a very good development what the Medical and Dental Practitioners Act provides, that any medical and dental practitioner must be registered before practicing medicine. This confers on the medical doctor right to practice medicine and ensures easy identification against quackery.

2.0.2 *Evolution Of The Medical Negligence Litigation (Medical Malpractice)*

The earliest reported case of medical malpractice was *Stratton Vs. Swanlond*[68] decided in 1374. The defendant surgeon tried to treat the plaintiff's mangled hand. The plaintiff claimed that she would be healed of her injury for pay. When she had been treated, and behold her hand got deformed, she sued the defendant. In the suit there was procedural error and it was dismissed. However, the judge pronounced some principles to be used in future cases and these are used up till today. The judge stated that doctors should be liable to patients when the patients are injured due to negligence. However, if the doctor exercises due care the liability would not be there. Also, in 1794, United States experienced its first medical malpractice. This was about the 5th year George Washington had his inauguration. The plaintiff had claimed that the defendant was negligent when he operated his wife. He also claimed that the defendant operated his wife in a most cruel and unskillful manner which led to her death. Like the case of *Stratton* mentioned

[67] A pregnant woman in labour due for delivery went to his hospital named- "Be Well Hospital" at Liverpool road, Apapa, to deliver, but died in the course of delivery. When he was arrested he confessed that he bought a medical certificate from his colleague at a sum of seventy thousand naira (₦70,000.00) only to obtain the fake certificate. Also he confessed that since 2005, when he started the hospital, only two patients died inclusive of this one.

[68] (1374) www.duhadduhadume.org "The First Medical Malpractice cases in Florida" AJR 2000 Jackson Ville Medicine; March

earlier the plaintiff believed that it was actual breach of contract. The plaintiff won this case receiving £40. The word malpractice is a Latin word which was composed by a Briton who is a lawyer named Sir William Blackstone as early as 1765 during his work on England Laws. The lawyer was displeased with the work of the physician describing it as negligent and unskillful. He described a Mala praxis as not a contract, but a private wrong.

The plaintiff, Mr. Pollard,[69] presented in the hospital with gallstone seeking for operation. At that time, there was no anesthesia and so he was tied down to the operating theatre to prevent pain and movement. The surgery that normally takes 1-5 minutes, took more than one hour. The surgeon used the most cruel and crude method using his hand to remove the gallstone. Subsequently, the patient died under 24 hours. The news of the patient's death reached the Lancet, a newspaper which published information about the whole saga and published it in his newspaper. Wakley, the journalist used that opportunity to highlight the need for medical standard. Dr. Cooper sued the journalist for liability seeking £2000 in damages. Wakley admitted that his article misrepresented Dr. Cooper's competence and the case was won by Dr. Cooper, even though Wakley only paid £100.

Most of the early medical malpractice cases were actually breaches of contract cases based on a claim that the physician promised to effect a cure. In *States Vs. Baker, and Stapleton*[70] a case decided in England in 1769, the court articulated a standard by which physician's conduct could be measured which was pro–physician. It was held that a physician could be found liable only if another physician testified that the defendant breached the standard of care, but the court went on to create a significant hurdle for the plaintiff in retaining an expert witness. The court

[69] The Historical origins of medical malpractice litigation. The Brody School of Medicine Naostie HER, Vol. 2. No.2 Fall 1999

[70] "America" First Medical Malpractice crisis, 1835 - 1865; Journal of Community Health, Vol.22 No4, August 1997

stated that an expert could only testify if he comes from the same locality as the defendant. That was absurd. This means that if there is no expert from the defendant's locality he loses the case. This is a resemblance of Bolams test. The surgeons have had it well right from the beginning. At that period all the surrounding cities know each physician in the town.

About 1832, Connecticut Supreme Court led down some standards of care that should be used universally and so it has been used universally today [71]. The court found in favour of the patient while the physician appealed. The physician argued that in Connecticut it is only gross negligence that can enable a surgeon to damages against malpractice. The Supreme Court upheld and abided by what the physician instructed. That if there was either carelessness or want of ordinary diligence, care and skill, then the plaintiff was entitled to receive damages.[72] Changes in the Society well as the evolution in medicine have all contributed to provide the environment for medical malpractice litigation to thrive.

For instance, between 1840 and 1860 the physicians experienced what they considered as a deluge of malpractice law suits. The number of cases in the Appellate Courts soared by 950% even though there was only 85% increase in the population. John Elwell[73], a lawyer-physician wrote a book on malpractice in which he claimed that there can hardly be found a place in a country where the eldest physicians in it have not been actually sued or annoyingly threatened. This means he was so bitter about all the happenings.

The loss of status in society by the physicians which started about the middle of 18th century contributed to the rise in the number and frequency of law suits. Furthermore, there was no

[71] "(1828): The First Recoded medical Malpractice litigation" in www.duhaime.org
[72] Malpractice Issues in Radiology AJR 2003, 181 – 1481 - 1486
[73] the new Jersey medical malpractice Liability insurance Crisis of 2002

standardization of medical education producing practitioners. This led to the production of incompetent physicians to deal with different complexities of human body.[74]

Take note: most developed countries globally use the word physicians for all doctors including surgeons, countries like UK, United States of America and others.

2.1.0. Surgery and surgeons

Surgery

Surgery is the branch of medicine involved in the treatment of injuries, deformities, or individual diseases by operation or manipulation. The Oxford Advanced Learners Dictionary defines surgery as medical treatment of injuries or diseases that involve cutting upon the body and often removing or replacing some parts.[75] It incorporates general surgery, specialized techniques such as Micro-Surgery, Cryosurgery, Minimally Invasive Surgery (M.I.S.) or Minimal Access (Key hole) Surgery, stereotactic surgery, and surgery associated with the main specialties, especially cardio-thoracic surgery, ophthalmology, gastroenterology, gynaecology, neurology, obstetrics, oncology, orthopaedics, transplantation surgery, reconstructive (plastic) surgery and urology and so on. There is also a remotely – controlled surgery using televisual robotic technique being developed.

Surgery is carried out in specially – designed operating theatres. Some surgical patients are treated as day cases for minor operations while others (major) are treated as in-patients for more complex surgeries, such as transplantation, neurosurgery and cardio – thoracic involving admission of patients into the hospital for few days before the operation to calm the patient and

[74] (2005): Independent study by Stephen Nehmer, July.
[75] The Oxford Advanced Learners Dictionary 6th Edition, 2000

acquaint him/her with environmental adherence and comfort. The surgeon admits the patient to allay fears that are always creating lingering fears that every surgery means a close brush with death. Certain operations have a particular psychological impact on the patient post operatively such as mastectomy (removal of breast for example, in breast cancer) and hysterectomy (for removal of the womb) for cancer bleeding or any other cause to save the patient. For prostatectomy, patients are warned that they may not ejaculate well again in life. These patients are reassured, and made comfortable, having had their consents in writing and informed of the risk of the operation.

2.1.1. Who then is a surgeon?

A surgeon

A surgeon is a person who has undergone a special course for a good number of years in the medical school and obtained a Bachelor of Medicine (M.B.) and Bachelor of Surgery (B.S) normally called MBBS. These two qualifications enable him to go for a residency training for further specialist training in one or more specialist courses in surgery (as mentioned above) to qualify as a specialist or an expert in one of the fields of surgery. He now obtains a Fellowship of West African College of Surgeons- (FWACS) Certificate in Nigeria, FRCS – Fellowship of the Royal College of Surgeons in United Kingdom and Fellowship of the American College of surgeons (FACS). Royal Australian College of Surgeon (RACS) of Australia and New Zealand and so on.

Globally, every country has its own fellowship. It is on record that nobody who has not got this qualification will ever practice as a surgeon anywhere in the world. Each regulatory Body of the fellowship has its own guiding principles on the surgical competence and performance, a guide

to and assessment and development of surgeons. If a surgeon for example from Nigeria wants to move to another country like U.K. or Australia, he/she must take the exams of those countries to qualify to practice in those countries. Being a surgeon carries a lot of responsibility for participation in lifelong learning and a willingness to monitor performance in the workplace.

2.1.2. The job of a surgeon

The job of a surgeon is a sensitive, difficult and tasking one in that it deals directly into the body of human beings. This is why both the local and international Professional Bodies of surgeons have a surgical competence and performance guide which presents a framework for assessing performance of practicing surgeons in all areas of surgical practice and across all of the defined College Competencies. One of these guides is the one from the Royal College of Australia and New Zealand (RACS).

In 2003, after consultation with the Fellowship and the Surgical specialty societies, the college identified nine competencies of a surgeon. These competencies under-pin all aspects of fellowship training and also provide the frame work to assess the performance of practicing surgeons. The College training and development programs contribute to certifying/recertifying surgeons across these nine competencies. They are:

- Medical Expertise
- Judgment – Clinical Decision Making
- Technical Expertise
- Professionalism
- Health Advocacy
- Communication

- Collaboration
- Management and Leadership
- Scholarship and Teaching

Each of these competencies is vitally and equally very important to the achievement of the highest standards of surgical performance[76]. It is therefore advised that Nigerian surgeons should imbibe these nine performance competencies for their highest standards of surgical performance and development.

2.2.0 CONCEPT OF NEGLIGENCE

In medical treatment, negligence is no different in law from negligence in any other discipline. The standards' and procedures are the same, whether for liability, for causation or for compensation. The term negligence may be used in numerous ways. Negligence may connote *carelessness* but this is not a legal connotation. This is because it cannot be acknowledged as the precise and suitable meaning of the term negligence since what is negligence in common parlance may fall short of negligence at law. In law, negligence and duty go together. The two are correlatives to one another. Lord Baron Alderson[77], 150 years ago, said Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable man would not do. This definition raises question as to reasonable man and test to determine a person as reasonable man. It cannot be regarded as a detailed meaning in terms of law as the concept of the duty of care was not mentioned. This is for the obvious reason that mere negligence in itself does not give a cause of action and to give a cause of action, the

[76] Collins et al, (2007) Royal College of surgeons of Australia and New Zealand.
[77] Blyth vs. Birmingham Waterworks Company (1956) 11 exch 781

negligence must be one which amounts to a breach of duty towards the person claiming negligence.

There are two different opinions which clarify or deal with the term negligence. Firstly, Winfield argues that negligence commonly suggests total or partial inadvertence of the wrong doer towards his conduct or outcome of his conduct.[78] In this context, negligence excludes or disregards intention. This means that there is no intention for the consequences. Therefore, undesired outcome are the yardsticks to differentiate negligence from intention. This implies that negligence as a tort is the breach of legal duty to take care which results in damages, undesired by the defendant to the plaintiff. This is usually tied to the inadvertence of the wrongdoer. That is, the wrongdoer does not deliberately cause the injury and never aims at bringing about the anticipated consequences but nevertheless exposes others to the risk of it. Therefore, the distinction can be drawn between negligence and intention. That is, negligence is a type of conduct, not a state of mind, not a fault or moral blameworthiness.[79] Accordingly, when one uses the expression negligence, it suggests lack of intention to cause the harm complained of.[80] It is not a mere conduct, but it is an unreasonable conduct as to the consequences of one's act.[81] Also, JS Colyer[82] points out that the term negligence may be used in two ways. Firstly, it is the name of a tort where the hurt brings an action against the wrong-doer for damages. Secondly, negligence itself is a sometime element of other torts. By this, negligence is a tort as well as a concept of the law of torts.

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[78]Jolowiz JA, Ellis Lewis T and Harris DM , Winfield on Tort, 9th edition, London: Sweet and Maxwell 1971, p 205

[79] the case of Working ton Dock and Harbour Board Vs SS Towerfield (owners) (1951) AC 112, 160. See also Houston RFV, Salmond on the Law of Torts, 17th edition, Sweet and Maxwell, 1977 p 193.

[80] the case of See Radcliffe Vs Barnard (1870) LR 6 Ch. 654; Dixon Vs. Muckleston (1872) LR 8 ch. 155; R Vs Senior, (1899) I QB 283.

[81] RamaswamyIyer, The Law of Torts, 7th edition Desai SK (ed) Tripati (p) Limited Bombay 1975, p 332.

[82] Colyer JS, A Modern View of the Law of Torts, 1st edition Pergamon Press, London, 1966 p 36.

Austin and Salmond[83] contend that negligence is a state of mind, not a conduct. By this, negligence is seen as a mental condition which should be punished by damages. Austin categorises different states of mind as needless, rashness or careless. However, critics criticise the Austin's understanding of negligence as criminalist type of negligence. To the critic, the different states of mind have no *locus* in the contemporary law of torts which takes into account only the external conduct of wrongdoer.[84] Therefore, negligence in the proper sense denotes a conduct rather than mental attitude. As a form of conduct, negligence presumes the existence of a duty of care. The idea of negligence and duty are correlative. Thus, if negligence were a mental attitude, it would be difficult to identify the existence of duty.

On this note, the court has emphasised the idea of duty on the part of the wrong-doer. A person is not negligent if he owes no duty towards someone.[85] In the case of *Donoghue vs. Stevenson,*[86] Lord Atkin said that, a man cannot be charged with negligence if he has no obligation to exercise diligence. A mere fact that a man is injured by another's act does not give rise to cause of action. The issue of negligence will not arise unless there is duty to exercise care.[87]

From the above, the development of two theories i.e. mental theory and conduct theory is noticeable. Salmond who is an advocate of state of mind theory draws difference between negligence and intention which involve mental attitude of the actor/doer towards the outcome of the act. This implies that a person is not guilty of negligence if he does not desire the consequences but nonetheless owing to carelessness or indifference, it may occur. Thus, a careless man is he who does not care-who is not anxious that his activities may cause loss to

[83] Fitzgerald P J, Salmond on Jurisprudence, London: Sweet and Maxwell 1963, 12th edition, 1967, at 390.
[84] Basu DD, Law of Torts, 8th edition, Practice Hall of India (p) Limited 1977,p 22.
[85] The case of Lievre Vs Gould (1893)1 QB 491.
[86](1932) AC 562.
[87] Grant Vs Australian Knitting Mills (1936) AC 86.

others. On the other hand, willful or intentional wrong doer is one who desires to bring out the anticipated consequence.

Therefore, negligence and wrongful intention are mutually inconsistent and mutually exclusive state of mind. The Salmond perspective was criticised by Holmes, Roscoe Pound, and Edginton[88] who considered mental theory as erroneous. To them, negligence does not involve or presuppose inadvertence or any other mental characteristic, quality, state or process. In fact, to Edginton, negligence is unreasonably a dangerous conduct.

However, it should be stated that it is not within the scope of this thesis to venture into jurisprudential details of the concept of negligence. The above views are relevant in order to understand the perception of authors as to when an act amounts to negligence. Therefore, the essence of this part is to provide a working definition within the objectives of this thesis. On this note, the researcher is not relying on the theories designed by scholars because none of the theories has been able to depict the contents of negligence. The theories are basically theoretical and would not be useful within the objectives of this thesis. Thus, the researcher intends to adopt the definition of negligence as given by Lord Wright in the case of *Lochgelly Iron and Coal Company vs. Mullan*.[89] Where he defined, negligence. He said, in law, to constitute negligence, it must possess the following three conditions;

a) That the defendant owes to the plaintiff a legal duty to exercise care;

b) That the defendant was in breach of that duty that is failure to exercise that duty of care

c) That as a result of breach, the plaintiff suffered damage.

[88] Edginton, P, Law of Torts, 1961, Oxford University Press, p 852.
[89] 1934, AC 1.

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

2.3.0 PROFESSIONAL NEGLIGENCE

Recent developments have revealed an enormous rise in negligence lawsuits involving people who are supposed to have acquired a certain professional status in society.[90] This kind of negligence seems to differ from ordinary negligence in a number of ways. Certainly, this can be said to have been the real motivation for writing this thesis. The evaluation of the supposed professional negligence cases will display that the courts rely on some characteristics which, it is proclaimed, are inherent to the nature of a profession. These characteristics include:

(i) Professional judgment. The courts rely on professional judgment or professional opinion in the assessment of the alleged negligent behaviour of the professional person.

(ii) An accepted or approved practice. This suggests that there is a connection between theory and practice and the manner in which professionals are educated.

(iii) Individual autonomy. A practitioner may deviate from an accepted practice within accepted parameters.

The above raises an apparent but vital question on why are the professions by reference to a certain practice, their supposed professional autonomy and professional opinion considered

[90]Ogiamien, T B E, "Medical Practice and the Law," *Nigerian Observer*, February 20, 1994, p 5; Akintola, S.O. (*2002)* "Medical Negligence in Nigeria: An Appraisal" *University of Ado-Ekiti Law Journal, Vol.1, pp.35-46;* Holbrook, J. (2003). The Criminalization of Fatal Medical Mistakes. *British Medical Journal*; 327(7424):1118-9

as competent to set their own standard in the performance of their duties?[91] This is above all a sociological issue. An answer encompasses an analysis into the nature and function of the professions in the socio-economic environment in which their members provide the professional service.[92]

However, as Freidson[93] pointed out, the expression profession is not straightforwardly defined. A single and united definition cannot be given and is yet to be given. He perceived the word as descriptive and evaluative. The definition differs in terms of the application, depending on the occupation involved and the purpose or intent of the definition is either malignant or analytical. Freidson does not attach any precise features to the word profession. He suggests that the word can be applied to those occupations that have obtained a degree of independence in the division of labour. This independence is a consequence of being in command over other occupations. The outcome is that the profession is autonomous and self-governing. This implies that its dominant position is granted through the trust worthiness of its members, which includes ethicality and knowledgeable skill.

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[91]Oluwatelure, F.A (1996) A scale to measure attitude to hypertension. *Journal of Educational Research and evaluation;* 1 (2), 251 – 255; Oyebode, F. (2006) Clinical Errors and Medical Negligence .*Advance Psychiatric Treatment*; page, 12(3); Ushie, B.A., Salami, K. K., Jegede, A. S., & Oyetunde, M. (2013) Patients" knowledge and perceived reactions to medical errors in a tertiary health facility in Nigeria, African Health Sciences 2013; 13(3): 820-828; Makeham M. A, Stormer S, Bridges-Webb C, Mira M, Saltman D. C, Cooper C and Kidd M. R. 'The Threats to Australian Patient Safety (TAPS) study: incidence of reported errors in general practice', Medical Journal of Australia. 2006; 185: 95-8

[92]Makeham M.A, Stormer S, Bridges-Webb C, Mira M, Saltman D.C, Cooper C and Kidd M.R. 'Patient events reported in general practice: a taxonomy', Quality and Safety Health Care, 2008; 17: 53-57; Weingart, S. N. 'Beyond Babel: Prospects for a universal patient safety taxonomy', International Journal of Quality in Health Care, 2005; 17: 93-94; Appelbaum P.S, Assessment of patient's competence to consent to treatment. New England Journal of Medicine.2007; 357:1834-1840; Bryden. D, Storey. I, Duty of care and medical negligence -Continuing Education in Anesthesia Critical Care & Pain Volume 11 Number 4 2011; Douglas. T, Medical Injury Compensation: Beyond 'No Fault', Medical Law Review,2009,Vol 17,p30-51

[93] Goldberg. R, Medical Malpractice and Compensation in the UK, 87 Chi.-Kent.L.Rev.131,2012; Hitzhusen. M, Crisis and Reform: Is New Zealand's No-Fault Compensation System a Reasonable Alternative to the Medical Malpractice Crisis in the United States?,22 Ariz. J. Int'l & Comp.L.649,2005; Johnson. L.L, Pre-trial screening of medical malpractice claims versus the Illinois constitution, The John Marshall Journal of Practice and Procedure (Vol. 10:133)(1976-1977)

Adopting Freidson's approach, this thesis puts a definition or description of professions in the perspective of professional negligence. In this perspective, some occupations are regarded to be professions and thus considered by the courts as substantially competent to determine an acceptable standard of competence. Examples of these professions are the medical, legal and accountancy professions.[94]

Furthermore, Carr-Saunders [95] defined a profession as an occupation based upon specialised intellectual training, the purpose of which is to supply skilled advice and service to others in return for a definite fee or salary. The two primary fundamentals in this definition are high level of specialised expertise and remuneration accordingly. Therefore, it can be stated that there is an agreement with regard to at least three unique factors describing or defining professions as different from other careers or occupations.

The first peculiar characteristic is the presence of specialised skill built upon intellectual training and knowledge. The intellectual content divorces professions from occupations and other skills. By this, the professional men are the suppliers or providers of the skill. The second differentiating feature is the ethicality of professional behaviour or social altruism. This aspect considers the ethics as paramount to the interests of the client or patient. This means that professional men owe not only a duty to the individual client or patient but also owe the duty to society as a whole. It emphasises not only the vocational aspect but it also means that this duty

[94]Kennedy. I, & Grubb .A, Medical Law: Text with Materials 452,Butterworths,2ed,1994; Kumar S., The relevance of humanism in medical profession, Indian J .Urol 2001;18:103-109; Lawrence H. Brenner JD, Alison Tytell Brenner MPH, Eric J. Awerbuch BA, Daniel Horwitz MD ,Beyond the Standard of Care-A New Model to Judge Medical Negligence, 2012,Vol 470,pp1357-1364; Liang. B.A, Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare,30 AM.J.L.& MED, 2004,vol 30:501-541;Liyanage.U, Applicability of the defence of informed consent against medical negligence in the scope of a patient's autonomy: A Sri Lankan perspective; Macintosh. J.C, Scoble. N.C, Negligence in Dellict (3rd ed.)Cape Town: Juta & Co. Ltd., 1948 at p.7; Mayberry MK, Mayberry JF, Consent with understanding: a movement towards informed decisions. Clinical Med 2002:2; 523-526

[95] Montrose. A, Is negligence an ethical or sociological concept? Med LR 1958; 21; 259; Samanta. A, Samanta. J, Legal standard of care: a shift from the traditional Bolam test by - Clinical Medicine Vol3, No 5 September/October 2003; Sohn. D.H, Sonny B, Medical Malpractice reform: The Role of Alternative Dispute Resolution, 2012, Vol. 470, pp1370-1378

towards society is sometimes wider and may surpass the duty owed to their clients or patients. The third unique feature is professional autonomy. It is said to be self-directive and self-regulatory. This aspect is reflected in the importance that the courts granted to the significance of professional judgment.

Therefore, bearing in mind the above mentioned unique features of a professional, it means that in the exercise of their skills, a professional could be liable for negligence for failure to take adequate care of his or her client or for not taking necessary precaution in the performance of their duties.[96]

2.4.0 CONCEPT OF SURGICAL NEGLIGENCE

The expression surgical negligence does not exist in a vacuum as some sort of clearly defined legal concept. It is always related to a particular fact or situation. It is for this reason that judicial decision in this area seldom creates any precedent that will necessarily dictate conclusion in a subsequent case.[97] Surgical negligence is called medical malpractice or medical malpraxis. However, this is not quite accurate since it includes all forms of irregular medical practices and makes no difference between professional negligence and professional misconduct.[98] There is no clear elucidation in law as to the nature of medical negligence. This vagueness leads to a state that it is not only a tort but also a crime. Yet, the law of surgical negligence is generated out of civil action. For instance, gross negligence or involuntary manslaughter constitutes criminal negligence. However, a simple carelessness or a mere failure of the practitioner to take care

[96]Teff H., The standard of care in medical negligence-moving on from Bolam? Oxford J Legal Studies 1998; 18; 473-84; Adila, H; Heywood, M & Berger, J (2007) *Health and democracy: A Guide To Human Rights, Health Law And Policy In Post-Apartheid South Africa* South Africa: Siber Ink

[97] Charles J Lewis, Clinical Negligence: A Practical Guide, (London: Butter Worths 2001) 5th edition p 139.

[98] Sir William Backstone, is the first person to use the word 'medical malpractice or praxis in 1768, Blackstone, 3 BI. Comm. 122.

amounts to tort. Gross criminal negligence occurs where the practitioner or health care provider has disregards for the life or safety of the patient and such act attracts punishment as a crime.[99] In terms of tort, negligence is said to be the breach of a duty caused by omission to do something which a reasonable man would or doing something a prudent and reasonable man would not do.[100] This makes no difference between medical negligence and any other type of negligence. Medical and non-medical negligence are the same. Yet, this definition has been followed by the courts of commonwealth nations including India.[101]

On this note, according to Gupta Kiran[102], surgical negligence is defined as the failure of a medical practitioner to provide proper care and attention and exercise those skills which a prudent, qualified person would do under similar circumstances. It is a commission of an act by a surgical professional which deviates from the accepted standards of practice of the medical community, leading to an injury to the patient. It could be defined as an incompetent unreasonable care and lack of skill of the surgeon to his patient. The incompetence could lead to adverse effect to his patient, whether it is history taking or some clinical examination, investigation, even if it is diagnosis or treatment that has resulted in injury, death, or an unfavorable outcome. Failure to act in accordance with the medical standards in vogue and failure to exercise due care and diligence are generally deemed to constitute medical negligence. In Nigeria, Dada J.A[103] defined medical negligence also as the failure of the healthcare provider to exercise the ordinary care and skill a reasonably prudent and qualified person would exercise under the same or similar circumstance.

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[99] See the case of R Vs Adomako (1995)1 AC 624.
[100]Paramananda KataraVs Union of India 1989 ACJ 1000 (SC).
[101]Guptha Jaiprakash, " Ethics and Law Controlling Medical Practitioners" AIR 2002 p 305
[102] Gupta Kiran "The Standard of Care and Proof in Medical Profession: A Shift from Bolam to Bolitho" (*2011*-2012) 1 *National Capital Law Journal,* XIV-XV.
[103] Encyclopedia Britannica

He went further to explain who the healthcare providers are; the doctors, nurses, surgeons, anesthetists, radiographers, dentists etc.

Eric Okojie defined professional negligence as the failure, on the part of a medical practitioner to exercise a reasonable degree of skill and care in the treatment of a patient. He gave an example of surgical negligence as the exhibit at the pathology museum in Edinburgh, Scotland where an exhibition of an eight–feet length of a small gut which was removed from a patient by a drunken gynaecologist. The gynaecologist had mistaken the gut for an umblical cord

Surgical negligence in a legal sense is a subdivision of professional negligence which is a division of the general concept of negligence that relates to the circumstances in which the surgeon/medical practitioner who represented himself or herself as having special knowledge breaches his or her duty to take care of his or her patient.[104] The general principle applies in showing that the surgeon who owed the duty of care is in breach of that duty. This means that once a surgeon has agreed to treat the patient, the legal relationship between surgeon and patient is established. This suggests that a medical relationship is formed and this relationship resulted in duty to take care. The basis of this legal relationship is the rule of reasonable reliance by the claimant on the skills of the defendant. On this note, the court observed that [105] Where a person is so placed that others could reasonably rely upon his judgment or his skill or upon his ability to make careful inquiry, and a person takes it upon himself to give information or advice to, or allows his information or advice to be passed on to, another person who, as he knows or should know, will place reliance upon it, then a duty of care will arise.

According to common law system of negligence, the medical practitioner has discretion in choosing the treatment which he proposes to give to the patient. This discretion is wider in

[104] Jackson & Powell, Medical Negligence Litigation: Time for Reform, PS Ranjan, *Medical Law and Ethics*.
[105] The case of *Hedley Byrne* v. *Heller*, (1964) AC 465

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

What can be deduced from the Hedley Byrne case, therefore, is that the necessary relationship between the maker of a statement or giver of advice (the adviser) and the recipient who acts in reliance on it (the advisee) may typically be held to exist where (1) the advice is required for a purpose, whether particularly specified or generally described, which is made known, either actually or inferentially, to the adviser at the time when the advice is given, (2) the adviser knows, either actually or inferentially, that his advice will be communicated to the advisee, either specifically or as a member of an ascertainable class, in order that it should be used by the advisee for that purpose, (3) it is known, either actually or inferentially, that the advice so informed may likely to be acted upon by the advisee for that purpose without independent inquiry and (4) it is so acted on by the advisee to his detriment.

So, a medical practitioner owes a duty of care to patients to ensure that they do not suffer any unreasonable harm or loss. However, where such a duty is found to be violated, a legal liability is imposed upon him or her, the owner of the duty, to compensate the victim for any losses they incur.[107] Surgical negligence can occur at various stages. For instance, a health care

[106] The case of *Caparo Industries plc* vs. *Dickman*(1990) 2 AC 605.
[107] The case of J*ames McNaughton Papers Group Ltd.* vs. *Hicks Anderson*,(1991) 1 All E R 134

provider may misdiagnose a problem, fails to treat the injury or illness properly, administer the wrong medication, and fails to adequately inform a patient about the risks of a procedure or about alternative treatments. In fact, surgical negligence comprises the majority of professional negligence lawsuits. This is not to say that medical professionals are more prone to committing negligence, but that they are the target of more professional negligence lawsuits. The legal position of surgical negligence in India has been described in several leading judgments. In the leading case of *Bolam vs. Friern Hospital Management Committee,*[108] *where* Mc Nair J. stated that where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art. Counsel for the plaintiff put it in this way, that as it concerns the medical man, negligence means failure to act in accordance with the standards of reasonably competent medical men at the time. That is a perfectly accurate statement, as long as it is remembered that there may be one or more perfectly proper standards; and if a medical man conforms with one of those proper standards of curse he should not be seen as been negligent. If a surgeon is not acting on the basis of competent practice hoping that because a body of opinion has a contrary view he should not be liable, he is joking with his job. But that does not mean to say that any medical practitioner can obstinately and pig-headedly move on with some outdated technique he cannot equally get away with it.

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

HWC Cox[109] attempts to define medical negligence as the breach of the duty owed by a doctor to his patient to exercise reasonable care and skill, which results in some physical, mental or financial disability. This definition appears to be replica of Winfield's definition of negligence in terms of tort or civil wrong. As pointed out, medical negligence is not different in law from any other type of negligence. It is very rarely an action for negligence between the doctor and the patient which may be initiated in criminal court. In view of this, Winfield defined medical negligence to be a form of negligence in which a patient brings an action for damages in civil court against his medical practitioner, who owed him a duty of care in tort, if he had suffered injury in consequence of negligence or unskilled treatment. Certainly, the term medical negligence is difficult to analyse. Negligence in medical treatment or surgical operation always relates to a particular fact-situation and what is decided in one case is usually of little help or may not help in deciding subsequent disputes. It is also very hard to foretell the consequence of the negligence in proving the case because of uncertainties surrounding the evidence and findings of fact. The ingredients of the negligence are a duty of care owed in a particular situation by the health provider to the plaintiff, a failure to discharge the standard of care required by the duty and a loss occasioned thereby to the patient that is recognised by the law and loss or damage foreseeable at the time of the wrongful act and deemed by the law to have been caused by that act. Therefore, to establish that a health–provider's negligence was negligence, a claimant must establish the following:

a. The healthcare provider owed a duty to the plaintiff;

b. The healthcare provider breached the duty;

c. The healthcare provider's breach caused the injury; and

d. The patient suffered damages because of the defendant's negligence.

[109] 2002-(CT2)-GJX-0447-J&K; 2003-(001)-CPJ-0612-J&K.

To sum up, medical negligence maybe described as want of reasonable care and skill or willful negligence on the part of a doctor in respect to acceptance of a patient, history taking, examination, diagnosis, investigation, treatment (medical or surgical) etc., resulting in injury or damage to the patient. For instance, prescribing treatment without taking history, without recording the signs and symptoms of disease, without investigation and diagnosis or not to carry out necessary tests before starting administration, failure to issue warning regarding side effects of the drugs or not monitoring the treatment, leaving foreign articles in the operation site, or performing operation on the wrong side of the patient, wrong dosage of injection, use of wrong drug or wrong gas during the course of anaesthesia are all examples of medical negligence. Therefore, medical negligence occurs when a doctor, dentist, nurse, surgeon or any other medical professional performs his job in a way that deviates from the accepted medical standard of care. In keeping with car accident analogy, if a doctor breaks the rules regarding how to treat a patient, and does something that is against the rules, then that doctor has failed to perform his duty, and is said to be negligent. However, the court will be having wide discretionary power in deciding the issue of surgical negligence. This will be examined in details in a separate chapter of this thesis.

2.5.0 PROOF OF SURGICAL 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. Medical negligence is usually the basis for a lawsuit demanding compensation for an injury caused to a patient by a doctor or other medical professionals. 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. That is, if a doctor administers medical treatment to a patient in a negligent manner and causes harm to him, the patient can bring an

action in negligence against the doctor claiming damages for the harm suffered. Therefore, in an action for surgical negligence, 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.

2.5.1 Duty of Care

Once a doctor undertakes to treat a patient, whether or not there is an agreement, a duty of care arises. The rules as to the duty of care in medical negligence cases are the same as the rules applicable to all other kinds of negligence. In law, there is no negligence unless there is, in the particular case, a duty to take care.[110] The duty of care is an essential element in civil wrong. This is because law does not take cognisance of carelessness in the abstract. It concerns itself only with situations when there is a duty to take care and where failure of that duty has caused damage. The duty signifies that one must not interfere with the lawful act of another.[111] The duty of care performs two distinct functions. Firstly, if the claimant is to succeed, it must be proved that the circumstances in which his damage or loss was caused were capable of giving rise to a duty of care and secondly, the defendant actually owed him a duty on the particular facts of the case.[112] The first requirement raises question of law while the second raises questions of mixed law and fact.

The question is how to determine the absence of a duty of care? It is suggested that the task of the court is to follow the established precedent. The next question is what is the alternative way

[110] Linden A.M. *Canadian tort law*, 6th ed. (Toronto: Butter worths, 1997) 284-99,
[111] (1996) Picard EI, Robertson GB. *Legal liability of doctors and hospitals in Canada*. p. 174, Scarborough, *Cars well*.
[112](1947) Lawson, Negligence in the Civil Law, 22 Tulane L. Rev. 32-36.

of deciding the notion of duty, in the absence of relevant precedent? Under this situation, the court has to examine the circumstances which warrant the existence of duty to be careful. The first attempt to formulate the principle was made by Lord Brett MR in *Heaven vs. Pender*[113] and in Lord Atkin, in *Donoghue vs. Stevenson*[114] that it is a right of every injured person to demand relief. This rule implies that everyone must take reasonable care to avoid acts or omissions which he can reasonably foresee would be likely to injure his neighbour. Here, a neighbour is one who is so closely and directly affected by another's act, this rule is what is known as principle of neighbour.

The concept of duty of care comes from a well-known case in which it was pointed out that everyone should take reasonable care to avoid acts or omissions that are likely to injure their neighbours. The word neighbour in this sense does not simply refer to the person living next door, but includes any persons who are likely to be affected by one's activities.[115] In this regard, doctors and other medical practitioners normally owe a duty of care to their patients when they are administering surgical/medical treatment. Once a surgeon or health care professional agrees to diagnose or treat a patient, he or she has assumed a duty of care towards the patient.[116] It should be mentioned that it is not enough to prove circumstances which give rise to a notion of duty, it is also necessary to establish that defendant owed a duty of care towards the plaintiff. The test for the existence of a duty owed to the person is in substance, neighboring principle that is foresight of the reasonable man. For this purpose, all circumstances must be taken into account including the sequence of events leading to the accidents. This will be more discussed in the chapter on judicial analysis.

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[113] (1883) 103, 104,105,124,170,178
[114] (1932) AC 562
[115]The case of *Goodes* vs. *East Sussex CC* [2000] 1 WLR 1356 (HL)
[116]Lochgelly Iron and Coal Company Vs. Mullan, 1934, AC 1, per se Lord Wright.

2.5.2 Breach of Duty

There can be no liability in negligence without establishing both duty of care and that there has been a breach of that duty, the standard of care is reasonable conduct under the circumstances. Generally, there is a duty on the part of everyone not to harm others. It does not mean there is a general duty to take care of others.[117] But, where there is an antecedent relation which imposes a duty to take care towards another, omission to take care that results in injury constitutes negligence or actionable wrong. Apart from contract, the duty to take care arises from the voluntary conduct of the party. Therefore, any person who undertakes to do something must use a reasonable care and caution to guard against the risk which is likely to cause harm or injury to others.

The test for deciding whether there has been breach of duty to take care would be the standard of an ordinarily careful man. It is not the foresight and caution of a particular man, who is capable of, but the foresight and caution of a prudent and reasonable man. In other words, the standard of care required by law is that of the reasonable man. It does not depend on the personal judgment of the defendant nor does the law require that he must exercise highest degree of care which the human nature is capable of. However, so far as professional service is concerned, a person to be a reasonable man has to exhibit certain amount of skill or competence which is usually associated with the efficient discharge of service. In case of a person who has engaged in a professional service, law expects him to exhibit the average amount of competence which is required for the proper discharge of duties of that profession, calling or trade.[118] If he falls short

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[117] Generally, Ian Freckelton, '*Rogers vs. Whitaker* Reconsidered' (2001) 9 *Journal of Law and Medicine* 5, 11. See also *Rogers vs. Whitaker* (1992) 175 CLR 479, 482 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ); *Chappel vs. Hart* (1998) 195 CLR 232, 271–2, 276 (Kirby J); *Rosenberg vs. Percival* (2001) 205 CLR 434, 477 (Kirby J).

[118]Thomas Addison, 'Negligent Failure to Inform: Developments in the Law since *Rogers vs. Whitaker*' (2003) 11 *Torts Law Journal* 165, 167–80.

of that and injures someone in consequence, he is said to have been in breach of his duty of care and not behaving reasonably. Law does not demand the highest degree of care and skill but rather requires the competence as an ordinary competent man.[119]

The Standard is objective and impersonal. What is material is not how the best he has acted in the particular situation, but whether he has acted as reasonable man. A reasonable man is presumed to be free from both over-apprehension and from over confidence, maintains calmness, collects information and remembers to take precautions against obvious dangers.[120] However, the standard leaves the judge to decide what, in the circumstances of the particular case, the reasonable man would have done and what accordingly ought to have foreseen.

2.5.3 Consequential Damage

The third component of the tort of negligence is the claimant's damage which must have been caused by the defendant's breach of duty and must not be too remote a consequence of it. In case of breach of contractual duty, the amount of damage will be assessed from the breach itself; in case of breach of duty not founded on contract, the plaintiff has to prove that damage has been caused to his person or property.[121] It is also necessary to prove that negligent act of the defendant is the direct and proximate cause of the damage. If the causal connection between the negligent act and damage is not direct, the damage is too remote; there is no remedy at law. The defendant is not guilty of breach of duty, when he has taken reasonable care as everyone is

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[119] *F vs. R* (1983) 33 SASR 189, 192 ff (King CJ), aff d *Rogers vs. Whitaker* (1992) 175 CLR 479, 488, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See, eg, *Rosenberg vs. Percival* (2001) 205 CLR 434; *KL v Farnsworth* [2002] NSWSC 382; *Henderson v Low* [2001] QSC 496; *Johnson vs. Biggs* [2000] NSWCA 338

[120] *Elbourne vs. Gibbs* [2006] NSWCA 127, where the patient claimed that the defendant surgeon had failed to warn him of a number of material risks of surgery to repair bilateral inguinal hernias which, in fact, materialised. The risks included: gross swelling of the scrotum; chronic pain resulting from nerve entrapment; and embolism. Evidence was given in relation to each risk that the patient 'would not have undergone the operation if he had been properly warned': at [34]–[37] (Basten JA), [1] (Beazley JA agreeing). See also at [97], [105] (Basten JA); *Ellis vs. Wallsend District Hospital* (1989) 17 NSWLR 553, 578–9, 582–90 (Samuels JA), 607 (Meagher JA agreeing) (non-disclosure of a risk of paralysis and failure to relieve pain following surgery, in circumstances where the patient would not have undergone the procedure and sustained quadriplegia had the slight paralysis risk been known).

[121] Pollock F, Torts 11th edition, Oxford University Press 1967, p. 455

expected to take, the damage would have occurred. In such a case, plaintiff is not entitled to any remedy. The full details on damages and remedies would be discussed in chapter five.

2.6.0. ISSUE OF DISCLOSURE

Provision of required information to the patient is one of the general obligations of the surgeon in the exercise of reasonable care. From the legal perspective, the inability of the surgeon to comply with the requirement deliberately or negligently will attract liability for any damage arising there from.[122] However, from the moral standpoint, informed consent has less to do with the liability of surgeons as agents of disclosure. It is more of autonomous choice of patients. Nonetheless, professionals have to provide information that will enable patients participate in decision-making process. This is for the obvious reasons that professionals are usually obliged to disclose an essential set of information including: (a) details or explanations of matters that patients generally see as material in deciding whether to refuse or consent to the suggested treatment; (b) the information professional believes to be material; (c) the professional recommendation; (d) the purpose of seeking consent; and (e) the nature and limits of consent as an act of authorisation.[123] Also, where research is involved, disclosures should cover the objectives and procedures of the research, predictable benefits and risks, any expected inconvenience or discomfort and the patient's right to withdraw without penalty from the research.

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[122] Abraham, K. S., and Weiler, P. C., "Organizational Liability for Medical Malpractice: An Alternative to Individual Health Care Provider Liability for Hospital Related Malpractice," unpublished paper, Richmond, VA, December 1992; American Healthcare Systems, and Johnson & Higgins, Inc., "Physician Office Practice Risk Management Manual," monograph, Washington, DC, 1989.

[123] American Medical Association. *Legal Implications of Practice Parameters* (Chicago, IL: 1990); American Medical Association, *Socioeconomic Characteristics of Medical Practice* (Chicago, IL: Center for Health Policy Research,1992);American Medical Association/Specialty Society Medical Liability Project, "A Proposed Alternative to the Civil Justice System for Resolving Medical Liability Disputes: A Fault-Based, Administrative System," monograph, Chicago, IL, January 1988; Bell, P. A., "Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts about the Deterrent Effect of Tort Liability," *Syracuse Law Review' 35(3):939-993,* 1984; Blumstein, J., "Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis," *Texas Law Review 59: 1345-1397, 1981*

On this note, the courts in US have established two significant criteria for ascertaining whether disclosure is sufficient. These are: the professional practice standard and the reasonable person standard, besides, the subjective standards have also gained recognition. In addition, an applicant must show that breach of this standard caused the injury.[124]

The professional practice standard holds that the professional has a duty to make the disclosure a reasonable medical practitioner would make under the same or similar circumstances. In this perspective, the amount and kinds of information to be disclosed is based on the professional custom.[125] For instance, disclosure of a treatment is a responsibility that goes to surgeons because of their professional expertise and commitment to the patient's welfare. As a consequence, expert evidence from members of the profession is required to prove whether the surgeon has violated a patient's right to information.[126]This standard is known as reasonable doctor standard. This poses some challenges. Firstly, it is uncertain in several circumstances whether a customary standard exists for the communication of information in medicine.[127] Secondly, if custom exists, can it be conclusive as to whether professionals have discretion to determine the scope of disclosure? Thirdly, it is also uncertain whether several surgeons have established skills to determine the information in their patients best interests. Finally, professional practice standard undermines the right of autonomous choices. In this premise, it

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[124]Bovbjerg, R. R., "Legislation on Medical Malpractice: Further Developments and a Preliminary Report Card," *University of Davis Law Review' 22:499-556, 1989;* Bovbjerg, R. R., "Reforming A Proposed Tort Reform: Improving on the American Medical Association's Proposed Administrative Tribunal for Medical Malpractice," *Courts, Health Science & The Law 1(1):19-28, 1990;* Bovbjerg, R. R., Sloan, F. A., Blumstein, J. F., "Valuing Life and Limb in Tort: Scheduling Pain and Suffering," *Northwestern University Law Review 83(4):908-76,* 1989

[125]Bovbjerg, R. R., and Tancredi, L. R., " Reform of the Medical Malpractice System Should Go Beyond ADR and Tort Law," *World Arbitration and Mediation Report3(3): 75-77* (London, England: BNA International Inc., 1992); Bovbjerg, R. R., Tancredi, L. R., and Gaylin, D. S., "Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System," *Journal of the American Medical Association 265(21):2836-2843,* June 5, 1991

[126] Brenner, R. J., "Medico-legal Aspects of Breast Imaging: Variable Standards of Care Relating to Different Types of Practice," *American Journal of Radiology 156:719-723,* April 1991; Burstin, H. R., Johnson, W. G., Lipsitz, S. R. and Brennan, T. A., "DO the Poor Sue More? A Case Study of Malpractice Claims and Socio-economic Status," *Journal of the American Medical Association 270(14):*1697-1701, 1993.

[127] Charles, S. C., Wilbert, J. R., and Franke, K. J., "Sued and Nonsued Physicians' Self-Reported Reactions to Malpractice Litigation, "American *Journal [of Psychiatry142(4):437-440,* April 1985

can be said that professional standards in medical care are required for medical judgments but decisions for or against medical cares which are non-medical decisions are within the provinces of the patient.

The standard of a reasonable person is one that determines the information to be disclosed by allusion to a hypothetical reasonable person. Whether information is pertinent or material is determined in terms of how a reasonable person decides as to adopt a procedure. Therefore, surgeons may be found guilty of negligent disclosures, even if their behaviour conforms to recognised professional practice.

However, the reasonable person's standard has conceptual, moral and practical difficulties. First, the concepts of material information and reasonable person have never been carefully defined. Second, questions arise about whether and how the reasonable person standard can be employed in practice. Its abstract and hypothetical character makes it difficult for surgeons to disclose information.[128]

The subjective standard obliges surgeons to disclose information by reference to the specific informational needs of the individual person, rather than hypothetical reasonable person. Therefore, individual needs differ due to beliefs and family history that demand diverse information than the reasonable person's needs. For instance, if a surgeon knows or has reason to believe that a person wants particular information then withholding it undermines autonomy. The issue is the extent to which the information should be disclosed. This is subjective. As a reasonable person, a surgeon has to know the patient's informational needs as such no expert testimony is required on the scope of disclosure, although expert testimony is generally necessary to prove the existence of risks and alternatives. The subjective standard is a sort of

[128] Charles. S. C., Wilbert, J. R., and Kennedy, E. C., "Physicians' Self-Reports of Reactions to Malpractice Litigation," *American Journal of Psychiatry 141(4):563-565,* April 1984; Crothers, L. S. '"Professional Standards Review and the Limitation of Health Services," Boston *University Law Review* 54(5):931-945 (1974)

moral standard of disclosure since a surgeon alone determines what information a patient needs.[129] Nevertheless, exclusive reliance on a subjective standard is not adequate in terms of law or ethics. It is also very difficult to know what information would be relevant for deliberation.

2.7.0. CONCEPT OF CAUSATION: BASIC PRINCIPLES

Causation at law arises in the perspective of assigning legitimate liability for a specific act, behaviour or omission. It involves a resolution of whether a respondent's behaviour played a part in bringing about the injury that is the subject of the applicant's negligent action. As such, it is not determined in relation to the relationship between conditions and occurrences suggested by scientific or theoretical theory.[130] Instead, it is grounded upon a consideration of the facts of a particular case when observed in light of the practical way in which the ordinary man's mind works in the every-day affairs of life. For this purpose, the common law has always recognised that there are two important questions involved in the determination of causation in tort. The first has to do with the factual aspect of causation, namely, the aspect that is concerned with whether the negligent conduct in question played a part in bringing about the harm, the subject of the claim.

The second part is concerned with the appropriate scope of liability for the magnitudes of tortious behaviour. In other words, the decisive question to be answered when addressing the second aspect is a normative one, namely, whether the defendant ought to be held liable to pay damages for the harm. Thus, in order to establish liability, including non-disclosure of risk, it

[129]Cm-ran, W. J., and Moseley, G. B., '. The Malpractice Experience of Health Maintenance Organizations," *Northwestern University Law Review* 70(1):69-89, 1975.

[130] Cameron, S & Lynch, A 'Undue influence, consent and medical treatment' (2003) 96 *Journal of the Royal Society of Medicine* 598*;* Brennan, T.A., Leape, L.L., Laird, Heart, Locaio, A.R., Lawthers, A.G., Newhouse, JP, Weiler, PC, and Hiatt, "Incidence of Adverse Events and Negligence in Hospitalized patients: Results of the Harvard Medical Practice Study" Qual Saf Health Czre, 2004: 13; 145-152

requires a plaintiff to prove factual causation, or that the defendant's negligence was a necessary condition of the incidence of the plaintiff's injury. This is a necessary condition that must be established when the harm happens.[131]

The implication of the above is that causation will be established if, on the balance of probabilities, the plaintiff's injury would not have happened but for the defendant's violation of his or her duty of care. At common law, while it is useful in defining the outer limits of liability where causation is disputed, the but for test was not considered as all-inclusive test of factual causation. Rather, it was considered that the results of the test yielded required tempering by common sense, or the making of value judgments such that normative issues could influence findings of factual cause.[132] Whether a factor ought to be a legitimately important cause in this manner calls for consideration. This requires a court to consider the appropriate scope of liability, or whether it is appropriate for the scope of the negligent person's liability to extend to the injury so caused. This demands an evaluation of whether or not and why liability for the injury should be imposed.[133] A comprehensive analysis of all normative matters capable of contemplation as part of scope of liability, if certainly imaginable, is outside the bounds of this thesis. Nonetheless, considerations falling under this element would include questions raised by intervening and successive causes foreseeability and remoteness; the terms of any applicable statute and, the imperative of the rule or duty of care violated.

2.8.0. CONCLUSION

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[131] Studdert, D.M., Brennan, T.A., Thomas, E.J. (2000). Beyond Dead Reckoning: measures of Medical Injury Burden, Malpractice Litigation, and Alternative Compensation Models from Utah and Colorado. *Indiana Law Review*, 22: 1643-1686

[132] Studdert, D.M., Mello, M.M., Gawande, A.A., Gandhi, T.K., Kachalia, A., Yoon, C., and Puopolo, A.L., Brennan, T.A. (2006).Claims, Errors, and Compensation Payments in Medical Malpractice Litigation. *The New England Journal of Medicine*, 354: 2024-2033

[133] Weiler D.C., Hiatt, H.H., Newhouse, J.P., Johnson, W.G., Brennan, T., Leape L.L. A Measure of Malpractice: Medical Injury, Malpractice Litigation and Patient Compensation. Cambridge Mass. Harvard University Press. 1993.

This chapter has examined some prominent concepts relating to the present study. The concept of negligence and surgical negligence was examined in order to lay the foundation as to when a medical practitioner and surgeons may be held liable for surgical negligence. The chapter also examines the methods and salient ingredients that must be proved in a case of surgical negligence. Furthermore, the issue of causation was examined since a person cannot be held liable for negligence when there is no nexus between his or her act and the outcome of such act resulting into negligence.

CHAPTER THREE

AN ANALYSIS OF THE LEGAL RIGHTS OF SURGICAL PATIENTS AND SURGEON'S DUTIES

3.0.0 INTRODUTION

This chapter is divided into two major parts. The first part examines the overall duties of a surgeon to a patient. The duties discussed in this chapter are not exhaustive but are limited to those that are directly linked with surgeons. Also, the analysis of the overall duties of surgeons will assist to understand some of the rights of a patient that emanate from such duties. This will assist as well as to determine the liability of a surgeon which will be a subject of discussion in another chapter of this study. The second part is dedicated to the examination of the legal rights of a surgical patient. This will lay a foundation as to the nature of liability of surgeons that have violated such rights.

3.1.0 SURGEON'S DUTIES TO HIS PATIENTS

This part will analyse the general duties of a surgeon to a patient. The discussion will not extend to the remedies available to a patient for breach of a surgeon's duties. This will be a subject of discussion in another chapter.

3.2.0 DUTY TO SEEK CONSENT OR APPROPRIATE AUTHORISATION

As a general rule, no operation, procedure or treatment may be undertaken without the consent of the patient, if the patient is a competent adult. Adequately informing patients and obtaining consent with regard to an operation, procedure or treatment is both a specific legal requirement and an accepted part of good medical practice. This means that public health organisations will clearly explain proposed treatment, including significant risks and alternatives in a way patients

can understand and obtain patient's consent before treatment, except in an emergency or where the law says patients must have treatment. Therefore, consent to the general nature of a proposed operation, procedure or treatment must be obtained from a patient. Failure to do this could result in legal action for assault and battery against a practitioner who performs the procedure.

As a general rule, all patients have a choice as to whether or not to undergo a proposed procedure, operation or treatment. While a patient might consent to a procedure once he or she has been informed in broad terms of the nature of the procedure, this consent will not amount to the exercise of choice unless it is made on the basis of relevant information and advice. Patients must also be provided with sufficient information about the condition, investigation options, treatment options, benefits, possible adverse effects or complications and the likely result if treatment is not undertaken. This will enable the patient make his/her own decision about undergoing an operation, procedure or treatment.

Generally, the law does not require consent or the provision of information, including warnings about material risks to be documented in writing. Indeed, patient's consent can be written either orally or in writing, or it can be implied from a person's conduct. However, consent obtained in writing will assist practitioners in any subsequent legal proceedings as it will support their views that the treatment has been discussed with the patient and that consent has been obtained especially consent before surgical operations.

For a patient's consent to be valid, a number of criteria will need to be met. First, the person must have the capacity to give consent, that is, the person must be able to understand the implications of having the treatment. Some examples of where patients are not considered as having this capacity include a child under the age of fourteen, some people affected by mental

illness, some people who are affected by dementia, brain damage or intellectual disability, and some people who are temporarily or permanently impaired by drugs or alcohol.

The second requirement is that consent must be freely given. The patient must not be pressured into giving consent. This would include pressure from hospital staff, a medical practitioner or family. Pressuring a patient into making a quick decision could be considered coercion.

Thirdly, the consent must be specific. It is valid only in relation to the treatment or procedure which the patient has been informed and has agreed to. Medical practitioners need to be aware that there is legal precedent whereby practitioners have been found liable for damages for trespass to the person if, when performing a procedure for which consent has been obtained, they undertake an additional procedure without obtaining specific consent for that procedure, even where the additional procedure appears desirable. Such specific consent is not required where during a procedure; further immediate treatment becomes necessary to save a person's life or to prevent serious injury to the person's health where the person is unable to consent.
Finally, the patient must be informed in broad terms of the procedure which is intended in a way the patient can understand.

The validity of professional relationship and medical treatment rendered by the surgeon can be challenged on the grounds of informed consent.[134] Health care providers must obtain appropriate authorisation before examining a patient or performing diagnostic or therapeutic procedures. If the patient is not a competent adult, the consent of some other persons or in the

[134] Katz. Jay, " Disclosure and Consent " in Genetics and the Law II, ed. Ed. A. Milunsky and G. Annas (New York: Planum Press, 1980), pp 122, 128; Katz. Jay, The silent World of doctor and Patient (New York: The Free Press, 1984) pp 86-87; Martin Gunderson, "justifying a Principle of Informed Consent: A Case Study in Autonomy Based Ethics", Public Affairs Quarterly 4 (1990): 249-65.

case of a child, the consent of the parent or guardian is necessary[135]. Medically informed consent law requires the disclosure of the risks, alternatives to suggested medical procedures so as to enable patients to make knowledgeable decisions about the course of their medical care.[136] When there is no consent or proper authorisation for a procedure, the surgeon or other practitioners doing the medical procedure can be liable for battery even if the procedure is properly performed, is beneficial and has no negative effects.

The terms informed consent did not receive much importance until the early 1970's.[137] Therefore, the focus has shifted from the surgeon's obligation to disclose information to the quality of a patient's or subject's understanding and consent. The reason behind this shift was the respect for autonomy of patients. The early history that concerned about informed consent shows that the informed consent had been used as a means to minimise the risk and avoid unfairness and since the mid-1970's the primary justification for focusing on the informed consent has been to protect autonomous choice of patients.[138]

Informed consent is an individual's autonomous permission about a medical intervention. An informed consent occurs in this context only when the patient or subject understands clearly without the control by others, intentionally authorises a health professional to do something and

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[135]Merz JF., "An Empirical Analysis of the Medical Informed Consent Doctrine: Search for a "Standard" of disclosure" retrieved from **www.fplc.edu/RISK/Vol2/winter/merz.htm accessed on the 12/2/2016;** Charles M. Culver and Bernard Gert, Philosophy in Medicine (New York: Oxford University Press, 1982), pp 123-26; Robert Nozick, " Coercion " in Philosophy, Science and Method: Essays in Honour of Ernest Nagel, ed. Sidney Morgenbesser, Patrick Suppes and Morton White (New York: St. Matins' Press, 1969), pp 440-72

[136] Clarence H. Braddock, Kelly A. Edwards, Nicole M. Hasenberg, "Informed Decision Making in Outpatient Practice: Time to get Back to Basics' Journal of the American Medical Association 282 (December 22/29, 1999); 2313-20; Michael J. Barry, "Involving Patients in Medical Decisions: How can Physicians Do Better?" Journal of American Medical Association 282 (December 22/29, 1999): 2356-57.

[137] See generally, Meisel "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision Making, 1979 WIS.L. Rev. 413; 487 (1979).

[138] Clarence H Bradock, "How Doctors and Patients Discuss Routine Clinical Decisions: Informed Decision Making in the Outpatient Setting," Journal of General Internal Medicine 12 (1997): 339-45; Dodd. F.J. "Consensus in Medical Communication", Social Science and Medicine 37 (1993): 565-69.

not otherwise on his/her body.[139] Mainly, there are two elements such as information and consent. The former refers to disclosure of information and the latter refers to voluntary decision and an authorisation to proceed.[140] Therefore, it is the duty of a surgeon or a medical practitioner to inform the patient of the nature of his or her sickness and to seek consent or permission before proceeding with any treatment.

3.3.0 Duty of Care

In terms of medical negligence, the term duty of care is synonymous to the concept of the undertaking towards the patient. The duty of care involves: (a) duty to possess special skill and knowledge; (b) duty to use caution in treatment/diagnosis; (c) duty to use diligence, care, knowledge, skill and caution in administering treatment.[141] The legal duty arises as soon as medical treatment is undertaken by the health care provider. Some commentators such as *Charles Lewis* stated that the duty arises simply out of the surgeon-patient relationship irrespective of the time at which treatment begins and the duration at which the treatment continues. The moment the doctor assumes the responsibility towards the patient, he establishes the duty of care.

Margaret Brazier[142] noted that where a patient establishes the surgeon/patient relationship, the doctor owes him a duty of care. As such, the duty of care does not arise until a definite undertaking of a procedure or hospital admission procedure is completed and the patient is allocated a bed. This idea has the advantage of certainty, the freedom of choice of the health care

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[139] Thomas Garrisso and Paul S. Applebaum, *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals* (New York: Oxford university Press, 1998) p11.

[140] Alan Meisel and Loren Roth, " What We Do and Do Not Know About Informed Consent ", Journal of the American Medical Association 245 (1981); 2473-77; National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, The Belmont Report (Washington, DC; DHEW Publication US 78-0012, 1978), p 10

[141] Charles J Lewis, Clinical Negligence: A Practical Guide, (London: Butter Worths 2001) 5th edition p 139.

[142] Margaret Blazer, Medicine Patients and the Law, 2nd (edi) London: Penguin, 1992, pp. 117-18.

provider and a proximate relationship between the parties but it is unable to take into account of the myriad complexities encountered in the practice of medicine.

Traditionally, the surgeon/patient relationship is fiduciary relationship. The patient reposes trust and confidence in the doctor by submitting himself under the care of the doctor without apprehension of life. Therefore, there is an obligation imposed on the doctor to take good care of his or her patient. Under no circumstances should the doctor cause harm to the patient since he is governed by the doctrines of ethics such as beneficence, non-malfeasance and paternalism. Accordingly, as far as persons engaged in the medical profession are concerned, every person who enters into the medical practice undertakes that he is seized of a reasonable degree of caution and expertise to render surgical/medical opinion and treatment. When a surgeon is consulted by a patient, such surgeon, owes the patient duty of care to wit:

(a) Deciding whether or not to undertake the case;

(b) Deciding on what treatment to give; and

(c) In administration of the treatment.

Where there is a breach in any of the above duties, negligence is said to have been established for which the patient gets a right of action for damages or on the basis of which the patient may recover damages from his doctor. The question whether a breach of duty has occurred is a subject of discussion in another chapter of this study.

3.4.0 DUTY TO MAINTAIN SURGEON'S CONFIDENTIALITY

One of common law duties imposed on a doctor is to respect the confidence of his patients. This obligation extends to all confidential information. There is a public interest in the maintenance of

confidence that law provide remedy for the breach of the obligation.[143] The rule of confidentiality enhances the doctor-patient relationship. Without this rule, patient will not entrust full, potentially intimate, details to the doctor. However, patient need not tell the surgeon that information disclosed be kept confidential, the obligation arises out of the existence of the relationship. The surgeon is under a duty not to reveal without the consent of the patient, information which he, the surgeon, has gained in his professional capacity.[144] An infringement of a person's right to confidentiality occurs only when the person or institution to whom the information was disclosed in confidence fails to protect the information or deliberately reveals it to third person without the consent of the patient. Thus, confidentiality imposes an obligation on the doctor not to disclose except in defined circumstances, information regarding his patient to a third party, whether third party is a relative or stranger.[145]

Rule of confidentiality has been recognised in Codes of Medical Ethics. They can be found in most ancient Greek literatures formulated by Hippocratic Oath some 2400 years ago[146] and continued in the WMAD 1968, which propounded obligation of absolute secrecy.[147] The World Medical Association's International Code of Medical Ethics which states the obligation of the doctor to preserve absolute secrecy and General Medical Council and British Medical Association guidelines state the confidentiality of information regarding patient.[148] The ethical

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[143] Mark Siegler, "Confidentiality in Medicine- A Decrepit Concept," New England Journal of Medicine 307 (1982): 1518-21; Bernard Friedland, "Physician-Patient Confidentiality: Time to Re-examine a Venerable Concept in Light of Contemporary Society and Advances in Medicine", Journal of Legal Medicine 15 (1994): 249-77.

[144] Barry D. Weiss, "Confidentiality Expectations of Patients, Physicians and Medical Students". Journal of the American Medical Associations 247 (1982): 2695-97.

[145] GMC's "Confidentiality": Protecting and Providing Information (2000); BMA Confidentiality and Disclosure of Health Information (1999).

[146] Hippocratic Oath 460 BC: whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart there form, which ought not to be noised abroad, I will keep silence thereon counting such things to be as sacred secrets.

[147] Declaration of Geneva as Amended at Sydney, 1968: "I will respect the secrets which are confided in me, even after the patient has died".

[148] GMC' booklet on Good Medical Practice, para 16 says: "Patients have a right to expect that you will not pass on any personal information which you learn in the course of your professional duties, unless they agree. If, in

rules apply to all branches of health care providers including nurses, physiotherapists and numerous others. Hence, if a disclosure is made in unauthorised circumstances, disciplinary action may follow provided a complaint is lodged. The punishment varies depending on the code of the particular branch of the profession involved.[149]

The issue concerning the rule of confidentiality would be, what is the basis for the rule? The rule being ethical code, does it possess legal status? Is it contractual, tortious, equitable, fiduciary or sue generis? As regards a private patient, the answer is very obvious. The right of confidentiality lies in contract because there is contractual relationship between the patient and the doctor/hospital or the health staff. The contract will either contain express terms of confidentiality or the court will read in an implied term to that effect in appropriate cases. On this note, the House of Lords has held that the doctor's duty to his patient was legally indivisible and that this duty though stems from the ethical code, it is also a legal duty enforceable at law.[150]

In India, leading authority concerning the issue of medical confidentiality is *Tokugha Yepthomi Vs Hospital Enterprise Ltd*.[151] In this case, a blood sample obtained from appellant employed by the Nagaland State Health Services found the blood group was HIV(+). On this basis, the appellant's marriage was called off on the ground that the appellant was found to be HIV (+). As a consequence of this, the appellant contended that he was entitled to damages for the breach of the information which was required to be secret under the medical ethics which obligated the respondent to maintain confidentiality and that his right to privacy had been infringed by the respondent by disclosing that he was HIV (+). The court opined that it is true

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exceptional circumstances you feel you should pass on information without a patient's consent, or against a patient's wishes, you should read our booklet 'confidentiality' and be prepared to justify your decision."

[149] Barry D. Weiss, "Confidentiality Expectations of Patients, Physicians and Medical Students". Journal of the American Medical Associations 247 (1982): 2695-97.

[150] The case of SidawayVs Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital (1985) AC 871

[151] (1998 (6) SCALE 230.

that in the doctor-patient relationship, the most important aspect is the doctor's duty of maintaining secrecy. A doctor cannot disclose to a person any information regarding his patient which he has earned during the treatment nor can he disclose the modalities of the treatment to anybody else the mode of treatment or the advice given by him to the patient. However, the Court went further to state that the rule of confidentiality was not absolute and that the disclosure is permissible where there is an immediate or future harm to others.

It is deducible from this decision that since proposed marriage carried with it the health risk to identifiable person who had to be protected from being infected with the communicable disease from the appellant, the right to confidentiality will not be enforceable. This decision of the Supreme Court, however, failed to frame a comprehensive code addressing issues such as disclosure by whom, to whom, under what circumstances and subject to what conditions.

3.5.0 THE DUTY TO ACCOMMODATE

The legal, professional and ethical obligation to provide services free from discrimination includes a duty to accommodate. Accommodation is a fundamental and integral part of providing fair treatment to patients. The duty to accommodate reflects the fact that each person has different needs and requires different solutions to gain equal access to care.[152]

A surgeon is required to take reasonable steps to accommodate the needs of existing patients, or those seeking to become patients, where a disability or other personal circumstance may impede or limit their access to care.[153] The purpose of doing so is to eliminate or reduce any

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[152] Ontario Human Rights Commission, Submission Regarding College of Physicians and Surgeons Policy Review: Physicians and the Ontario Human Rights Code, (Ontario: August 1, 2014).

[153]Section 1 of the Human Rights Code, R.S.O. 1990, c. H.19 defines "disability" as follows:

> (a) any degree of physical disability, infirmity, malformation or disfigurement that is caused by bodily injury, birth defect or illness and, without
> limiting the generality of the foregoing, includes diabetes mellitus, epilepsy, a brain injury, any degree of paralysis, amputation, lack of physical
> co-ordination, blindness or visual impediment, deafness or hearing impediment, muteness or speech impediment, or physical reliance on a

barriers or obstacles that patients may experience.[154] Surgeons must comply with their duty to accommodate by providing accommodations in a manner that is respectful of the dignity, autonomy and privacy of the person. Examples of accommodation may include: enabling access for those with mobility limitations, permitting a guide dog to accompany a patient into the examination room, ensuring that patients with hearing impairment can be assisted by a sign-language interpreter, being considerate of older patients that may face unique communication barriers.

It should be stated that while surgeons have a legal, professional and ethical duty to accommodate; there are limits to this duty. Surgeons do not have to accommodate beyond the point of undue hardship, where excessive cost, health or safety concerns would result. The duty to accommodate is also limited where it significantly interferes with the legal rights of others.

3.6.0 OTHER DUTIES

3.6.1. Duty to consult or refer to specialist: Where a surgeon knows that the diagnosis or treatment is beyond his capacity, or involves very high complications, it is his duty to invite another surgeon who has the necessary ability or refer the patient to a specialist.[155] If he fails to do so by attempting to diagnose himself or undertaking the task beyond his competence, he will be negligent if harm occurs to the patient.[156] For instance, if a doctor suspects cancer, he should

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guide dog or other animal or on a wheelchair or other remedial appliance or device,
(b) a condition of mental impairment or a developmental disability,
(c) a learning disability, or a dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,
(d) a mental disorder, or
(e) an injury or disability for which benefits were claimed or received under the insurance plan established under the Workplace Safety and Insurance
Act, 1997.

[154]Further explanation of "undue hardship" is provided in the Ontario Human Rights Commission's Policy and Guidelines on Disability and the Duty to
Accommodate.

[155] International Code of Medical Ethics: Duties of physician to sick.

[156] Moses vs. North West Herefordshire Health Authority 1987, C.A; (unreported) cited in Michael A Jones n 318 p 302.

immediately refer the patient to a specialist or arrange for an immediate biopsy. Failure to do so constitutes negligence. Similarly, a consultant in expertisation who has not come across the difficult problems in treatment will have the obligation to refer to a specialist or seek the advice from the specialist concerned.[157] Also, where a doctor cannot interprete a cytology report correctly, there is an obligation on him to seek clarification of the report and advice for further investigation.[158] In *Poole Vs Morgan*,[159] wherein the ophthalmologist who did not have training as to the use of laser, performed retina vitreous which was normally done by the specialist. It was found that since he has not possessed expert skill, it was his duty to refer the patient to such a specialist and as such, he was found guilty of negligence.[160]

3.6.2 Duty to inform about risks: The doctor must disclose to the patient about the medical condition and the method of treatment and risk of treatment to enable the patient to decide whether to accept or refuse the treatment. It is not only the doctor's duty of care to warn about the inherent risk of the treatment. It is also his duty to inform the patient what has gone wrong in the provision of treatment.

Until 1950s, the disclosure of information had been considered as a matter within the discretion of the doctor's professional judgment. However, in **Sidaway's[161] case,** the court pointed out that it was the duty of the doctor to answer the patient's questions about the proposed treatment. This approach reflects that the practitioner is no longer enjoying the medical paternalism which has been practised by the doctor since the time of Hippocratic Oath. Thus; In *Stamos Vs Davis,*[162]in

[157] Gascoine vs. Ian Sheridan (1994)5 Med. LR 437, at 447 where a consultant gynecologist was encountered with an unexpected problem of an invasive carcinoma* following the operation of a simple hysterectomy.
[158] Wilson Vs. Vancsouver Hockey Club 91983)5 DLR (4th) 282 at 288.
[159](1987)3 WWR 217.
[160] Ibid.
[161] (1985)AC 871.
[162] (1986)21 DLR (4th) (Ont. HC); However, the General Medical Council now, has issued some guidelines to doctors in connection with giving information to patient/relatives when something goes wrong with the treatment.

the course of undertaking biopsy, the petitioner's spleen got punctured, but the defendant answered in casual way that he did not get what he wanted. Thus, he withheld the information regarding ruptured spleen. A few days later, the patient was admitted in the same hospital where the spleen was removed surgically. It was held that the defendant was under a duty to inform the patient that his spleen had been punctured. This failure was a breach of duty.

3.6.3 Duty to give instructions: It is not the simple case of giving instructions, the healthcare provider in doing so should exercise special care to ensure that the patient has understood the instructions as well as importance of following them up. This obligation encompasses various subjects like advice about the treatment; risk involved therein, lifestyle of the patient, side-effects of the treatment and diet.

A failure on the part of healthcare provider to provide instruction regarding potential danger involved in the treatment will amount to negligence. In the case of *Clark vs. Adams,*[163] the plaintiff was treated by the defendant - physiotherapist for a fibrocystic condition of his left heel. The defendant before applying treatment states: when I turn on the machine, I want you to experience comfortable warmth and nothing more; if you do, I want you to tell me. As a consequence of the treatment, the plaintiff suffered injury by burning which eventually led to the amputation of left leg below the knee. The court found that the warning given was inadequate to enable the plaintiff to be safe. The safety of the plaintiff depends upon the proper instructions of the practitioner. Thus, the court has recognised the competent patient's right to understand his treatment as inalienable right in terms of the medical care.

3.7.0 LEGAL RIGHTS OF SURGICAL PATIENTS

See GMC Good Medical Practice, May 2001. In India Medical Council has not made such an attempt to enlighten professionals with the patients' right to know the effect of the treatment.

[163](1950) 94 Sol. Jo 599.

The passing of the Universal Declaration of Human Rights, 1948 and assent by states to the International Covenants on Civil and Political Rights, 1966 and the Economic, Social and Cultural Rights, 1966, has brought a global recognition to the protection of human rights. The question of patients' rights has also been brought to prominence with the introduction of contemporary technology and the use of artificial measures to protect human life.

Aside those international instruments setting out human rights, most national constitutions have equally set out basic rights of individual. In this milieu is the Constitution of the Federal Republic of Nigeria, 1999 [as amended] which sets out fundamental human rights enjoyable by every citizen of Nigeria (patients inclusive). Therefore, the violation of these rights could be challenged in court and the violator may be liable to pay huge compensation.

The fiduciary nature of the surgeon/patient relationship requires that surgeons act in their patients best interests. In doing so, surgeons must strive to create and foster an environment in which the rights, autonomy, dignity and diversity of all patients, or those seeking to become patients, are respected. Therefore, this part examines the legal rights of surgical patients. These are rights that emerged from the relationship between surgeon and patients. Some of these rights are contained in the international human rights instruments and the national constitution of a state while some are provided for in other enabling laws.

3.8.0 RIGHT TO PRIVACY

International and regional human rights treaty bodies, courts, commissions and independent experts have all provided relevant guidance with regard to the scope and content of the right to privacy, including the meaning of interference with an individual's privacy.[164] In its general

[164]*See* City of Santa Barbara vs. Adamson, 610 P.2d 436, 439 (Cal. 1980) ("The right of privacy is the right to be left alone. It is a fundamental and compelling interest. It protects our homes, our families, our thoughts, our emotions, our expressions, our personalities, our freedom of communion and our freedom to associate with the people we choose."

comment No. 16, the Human Rights Committee underlined that compliance with article 17 of the International Covenant on Civil and Political Rights required that the integrity and confidentiality of correspondence should be guaranteed de jure and de facto. Correspondence should be delivered to the addressee without interception and without being opened or otherwise read.

The right to privacy is protected in several human rights documents both national and international. Article 12 of the Universal Declaration of Human Rights provides that no one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.[165] The International Covenant on Civil and Political Rights, to date ratified by 167 States, provides in Article 17 that no one shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, or to unlawful attacks on his or her honour and reputation.[166] It further states that everyone has the right to the protection of the law against such interference or attacks. Furthermore, in the Nigerian Constitution, the right to privacy is clearly provided for. For instance, Section 37 of the Constitution provides that[167] the privacy of citizens, their homes, correspondence, telephone conversation and telegraphic communications is hereby guaranteed and protected.

Like the International Convention on Civil and People's Right (ICCPR), the Nigerian Constitution set restrictions on the right to privacy. It is on this premise that section 45 of the Constitution provides that nothing in section 37 shall invalidate any law made that is reasonably

[165] the Universal Declaration of Human Rights 1948. For more details view, see William L. Prosser, *Privacy*, 48 CAL. L. REV. 383, 389 (1960). For a broad survey of the right to privacy, see generally RICHARD C. TURKINGTON & ANITA L. ALLEN, PRIVACY LAW: CASES AND MATERIALS (2d ed. 2002).
[166] International Covenant on Civil and Political Rights 1966
[167] Constitution of the Federal Republic of Nigeria 1999 [as amended] 2011

not justifiable in the interest of defence, public safety, public order, public morality and public health.[168] Going by Article 17 of the ICCPR, interference with privacy is not permissible if it is unlawful and arbitrary. This means that interference with an individual's right to privacy is only permissible under international human rights law if it is neither arbitrary nor unlawful.[169] In its general comment No. 16, the Human Rights Committee explained that the term unlawful implied that no interference could take place except in cases envisaged by the law. Interference authorised by states can only take place anchored on law.

The fundamental question here is how a right to privacy is truly a right to a surgical patient. As earlier discussed, a surgeon is duty bound to protect and respect the confidence of his patients. The doctor is under a duty not to reveal without the consent of the patient, information which he, the doctor, has gained in his professional capacity.[170] An infringement of a person's right to confidentiality occurs only when the person or institution to which the information was disclosed in confidence fails to protect the information or deliberately reveals it to third person without the consent of his or her patient. This means that right of confidentiality is an integral part of the right to privacy. Therefore, a disclosure of any information by a doctor or a surgeon without the consent of a patient will be a great breach of the individual's rights to privacy. In India, confidentiality right had been acknowledged as an offshoot of constitutional right to privacy.

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[168] City of Santa Barbara vs. Adamson, 610 P.2d 436, 439 (Cal. 1980) ("The right of privacy is the right to be left alone. It is a fundamental and compelling interest. It protects our homes, our families, our thoughts, our emotions, our expressions, our personalities, our freedom of communion and our freedom to associate with the people we choose."

[169] Konvitz, *Privacy and de Law: A Philosophical Prelude, 3* 1 LAW & CONTEMP. PROB. 272 11966) for a discussion of the historical development of a right to privacy beginning with Biblical and ancient Greek conceptions;

[170] Barry D. Weiss, "Confidentiality Expectations of Patients, Physicians and Medical Students". Journal of the American Medical Associations 247 (1982): 2695-97.

In fact, the Supreme Court of India has re-affirmed that doctors are morally and ethically bound to maintain confidentiality. In such situation, public disclosure of even true private facts may amount to a breach of the constitutionally guaranteed right to privacy which often times clashes with the individual's right to chose when to be left alone and another's freedom to be informed.[171] Somewhat, depending on the situation of each case, the right to individual's privacy of a patient is not absolute. The Nigerian Constitution has provided for some instances where a patient's right to privacy may be derogated from. This means that a disclosure of private information may be justified on the altar of defense, public safety, also public order, and public morality and public health.[172]

3.9.0 RIGHT OF PATIENT TO ACCESS INFORMATION

The issue of access to information poses two questions: does the patient have unfettered access to personal medication information? Also, at law, who owns and controls intimate information? Before going to quest for answer, it is pertinent to examine the issue from human rights angle. WHO document with unequivocal language talks about rights of information access as follows:[173]

a) All information must be kept confidential, even after death;

b) Information can only be disclosed if the patient gives explicit consent or if the law specifically provides;

c) All identifiable data must be protected;

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[171] Lawyers Collective-HIV/AIDS Unit Judges' Workshop on HIV/AIDS Mumbai 7-8 January 1999 " Confidentiality " Outline of presentation by Mr. Justice Edwin Canicron High Court of South Africa, cited from www.hri.ca/partner/unit/condientiality cameron.htm; also see AIR 1995 SC 495.

[172] City of Santa Barbara vs. Adamson, 610 P.2d 436, 439 (Cal. 1980) ("The right of privacy is the right to be left alone. It is a fundamental and compelling interest. It protects our homes, our families, our thoughts, our emotions, our expressions, our personalities, our freedom of communion and our freedom to associate with the people we choose."

[173] World Health Organization Document: Promotions of the Rights of Patients in Europe-Proceedings of a WHO Consultation (Kluwer, 1995) p 2.

d) Patients have the right of access to their medical files and so forth which pertain to diagnosis, treatment and care;

e) Patients have right to require the correction, completion, deletion, clarification or updating of personal and medical information concerning them which are inaccurate, incomplete, ambiguous, outdated or which are not of use for diagnosis sake, treatment and care; and

f) Information may only be withheld from patients exceptionally where there is good reason to believe that the information would, without any expectation of obvious positive effects, cause them serious harm.

However, neither the WHO document nor medical law makes an attempt to address a basic question of who owns the information. In the past, a patient had no access to medical data, and as such, the recourse for it was an illegal action. Now, it is the right of the patient to see his own medical data. In Europe, in 1984 the Protection Act was replaced in 1998 by the Protection Act Data. The Act was enacted in response to the EU Data Protection Directives1995 which covers not only computerised data but also data which is manually stored in filing systems. However, data may be refused depending on the condition of the patient that needs the disclosure and it could be for his interest.

In Nigeria, the newly passed Freedom of Information Act has given a person the access to right of information.[174] Information is defined in section 31 to include all records, document and information stored in whatever form, including written, electronic, visual images, sound and audio recording. Therefore, this Act is of general in nature as it applies to all situations. It could however be employed by a patient to request for his or her personal records from the doctor. In

[174] The Freedom of Information Act 2011.

fact, the Act in section 7 makes it actionable against persons or authority who has refused to supply the information.

3.10.0 THE RIGHT TO LIFE

Section 33 of the 1999 Nigerian Constitution[175] provides for the right to life and states further that no one shall be deprived intentionally of his life save in execution of the sentence of a court in respect of a criminal offence in which he has been found guilty. The effect of this provision is that everyone including a patient has a right to life and the section imposes a duty on everyone, including the health care provider to take reasonable/absolute care when treating the patient and must ensure that the consequence of such treatment does not result to death. In this wise, a patient must not be subjected to surgical experiment with the resultant effect of causing death of the patient. Since a patient has a right to life, this imposes a corresponding duty on his health care personnel not to act in such a way that will deprive such a person his right to life. If in the course of treatment, surgical/medical personnel acts negligently in such a way that causes the death of a patient, such surgeon or officer may be prosecuted either for the offence of murder or manslaughter depending on the facts and circumstances of the case.

The case of *Surgeon Captain C.T. Olowu vs. Nigerian Navy*[176]*is illustrative here.* The facts of this case: the appellant, a consultant obstetrician/gynaecologist, was deployed to Nigerian Navy Medical Centre as part of his military assignment, as a military medical officer and as a commander of the medical Centre. One of his patients, one Mrs. Joy Bassey, and obstetric patient for antenatal care was rushed to hospital in labour on the 2nd of April 1999. She was a high risk patient, having had a caesarean section for a still birth in her previous first pregnancy. She was registered in that Navy Medical Centre, a wife of a Navy Officer. On arrival

[175] Section 33 (Right to Life) as amended of the 1999 Constitution of the Federal Republic of Nigeria
[176] (2011) Friday, 9th December, S.C. 182/2007 (Pt 21) Page 161 (Medical Law Report):

to the Medical Centre, she was received by the nurses on duty who conducted the preliminary tests and discovered that her discharge was mecunium-stained. (meciniunm –stain is a brownish coloured stain that depicts that the foetus in utero is in imminent danger. If immediate step is not taken within the shortest period of discovery, the foetus dies within five minutes to one hour.). That was an indication for an impending complication. The appellant was immediately notified of the nurses observation on the patient. The Appelant arrived to the medical Centre about seven p.m and asked the nurses some question without personally examining the patient and left. He did not come back to the medical Centre until the next day, at which time the patient's condition had deteriorated, despite the fact that he was aware of the patient's previous medical history. The appellant only came back the next day at 11 a.m. i.e. on the 34 1999 merely to write a referral letter for the patient to be transferred to Yaba Military Hospital, her situation having become bad as she was bleeding profusely per vaginam. At Yaba Military Hospital, she was taken to the theatre for immediate surgery, where it was discovered that the foetus had died two hours ago in utero and the uterus had ruptured. She had emergency hysterectomy (removal of the uterus) which means she would never have any child again in life. This all was an outcome of a prolonged labour at the Navy Medical Centre. The appellant was subsequently arraigned for negligence. When hearings and addresses have been concluded by the counsels, the appellant was pronounced guilty as charged. His appeal to both the Court of Appeal and the Supreme Court failed. The Supreme Court, was led by M.S. Muntaka –Coomasie J.S.C, sentenced him to manslaughter with no option of fine.

3.11.0 THE RIGHT TO PROTECTION OF HUMAN DIGNITY

Section 34 of the Nigerian Constitution[177] provides that every individual is entitled to respect of the dignity of his person and should be accorded such respect irrespective of the gender, creed, ethnic affiliation n and others.

Like the right to life, the right to human dignity is so important and it is an acknowledgement of the intrinsic worth of human being. The right to dignity also imposes a duty on the surgeon/healthcare provider to respect the worth and person of his/her patient. His person must be respected and must not be treated in a most cruel, inhuman and degrading manner. No matter the state of patient's health and his medical ailments, he is entitled to the right to humane treatment at all times. Otherwise, the patient may bring an action for the breach of his right to human dignity in the course of receiving surgical/medical care. It is submitted that any patient prejudiced against, whether HIV-positive patients, Lassa fever patients or even the eliminated Ebola disease in the hospitals, no matter the state of his health or the nature of his sickness has the right to his/her personal dignity and could sue the surgeon for a breach.

3.12.0 RIGHT AGAINST DISCRIMINATION[178]

The various human rights instruments articulate the right of everyone to receive equal treatment with respect to services, goods and facilities, without discrimination on the grounds of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. This requires that all those who provide services, including surgeons providing health services do so free from discrimination. Discrimination may be described as an act, decision or communication that

[177] Section 34 of the 1999 Constitution of the Federal Republic of Nigeria
[178] Section 42 of the 1999 Constitution of the Federal Republic of Nigeria

results in the unfair treatment of a person or group by either imposing a burden on them, or denying them a right, privilege, benefit or opportunity enjoyed by others.

Discrimination may be direct and intentional. Alternatively, discrimination may be entirely unintentional, where rules, practices or procedures appear neutral but may have the effect of disadvantaging certain groups of people. The right against discrimination provides protection from all forms of discrimination based on the above protected grounds, whether intentional or unintentional.

3.13.0 RIGHT OF ACCESS TO CARE[179]

Surgeons must provide information about all clinical options that may be available or appropriate to meet patients' clinical needs or concerns. Surgeons must not withhold information about the existence of any procedure or treatment because it conflicts with their conscience or religious beliefs. Where surgeons/physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible surgeon, other health-care professionals, or agency. The referral must be made in a timely manner to allow patients to access care. Patients must not be exposed to adverse clinical outcomes due to a delayed referral. Surgeons must not impede access to care for existing patients or those seeking to become patients.

Furthermore, where surgeons object to providing certain elements of care for reasons of conscience or religion, surgeons must communicate their objection directly and with sensitivity to existing patients, or those seeking to become patients. They should inform the patient that the objection is due to personal and not clinical reasons. In the course of communicating their objection, surgeons must not express personal moral judgments about the beliefs, lifestyle,

[179] International Human Rights of 1968

identity or characteristics of existing patients, or those seeking to become patients. This includes not refusing or delaying treatment because the surgeon believes the patient's own actions have contributed to their condition. Furthermore, surgeons must not promote their own religious beliefs when interacting with patients, or those seeking to become patients, nor attempt to convert them.

3.14.0 THE RIGHT TO SELF-DETERMINATION[180]

Informed consent is one of the central concepts of present-day medical ethics. The right of patients to make decisions about their healthcare has been enshrined in legal and ethical statements throughout the world. The WMA Declaration on the Rights of the Patient states that the patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions[181]. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what should have been the implications of not giving consent.

The Nigerian Supreme Court decision in the case of the *Medical and Dental Practitioners Disciplinary Tribunal vs. Dr. John E. N. Okonkwo*[182] recognises the right of a patient to self-determination in the context of the freedom of thought, conscience and religion. In that case, one Mrs. Martha Okorie (the patient), her husband and Dr. John Emewulu Nicholas Okonkwo all belong to the Jehovah's Witness, a religious sect that believes that blood transfusion is contrary to God's injunction. The patient, a 29 years old woman having had a

[180] Section 37 and 38 of the 1999 (as amended) constitution of the Federal Republic of Nigeria
[181] Male vs. Shulman, (1990) 47 DLR 4th edition 18 at 24
[182](2001) 2 MJSC 67.

delivery at a maternity home on 29/7/91 and was admitted at the Kenayo Specialist Hospital for a period of nine days from 8/8/91, because she had difficulty in walking and severe pain in her public area.

A diagnosis was carried out and it was discovered that she had a serious ailment for which blood transfusion was recommended, but she refused to give consent to the treatment. On that ground, the Doctor at the Kenayo Hospital discharged her with a note that Mrs. Martha having refused the blood transfusion not minding how much we have pleaded with her and the treat to her life which may kill her. Her husband then took her to Jeno Hospital on 17/8/91delivered the letter to Dr. Okonkwo by the patient herself witnessed by her husband and her uncle. The letter was titled Medical directive/release. In that card, she directed that no blood transfusions be given to her even though the physicians deemed such vital to her health or life. She stated that the directive was in accordance with her rights as a patient and her beliefs as one of the Jehovah's witnesses. She accepted any added risk the refusal may bring and released doctors, anesthesiologists, hospital and their personnel from responsibility. The husband further signed another document on 17/8/91 wherein he instructed that blood should not be transfused on his wife and therein released Jeno Hospital and its personnel from any liability on the issue. The respondent proceeded to treat the patient in accordance with her directive that is without blood transfusion but she died on 22/8/91.

The respondent was charged before the Medical and Dental Practitioner Disciplinary Tribunal on two counts of negligent and acting contrary to his oath as a medical practitioner and thereby conducted himself infamously in a professional respect contrary to the Medical and Dental Practitioner Disciplinary Act. The Tribunal found the respondent guilty of the two counts and suspended him from the profession for a period of six months. The respondent appealed to

the Court of Appeal which allowed the appeal. The Medical and Dental Practitioner Disciplinary Tribunal thereafter appealed to the Supreme Court.

The case also confirmed the common law position that there are some degrees of constitutionally protected liberty interest in avoiding unwanted medical treatment, including life-sustaining medical treatment such as artificial nutrition and hydration and blood transfusion. The Supreme Court[183] unanimously held that 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 religious: section 35. All these are preserved in section 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 unauthorized invasion. The right to freedom of thought, conscience and 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 life, 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 the 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.

[183] Supreme Court decision in the case of medical and Dental Practitioner Disciplinary Tribunal vs. Dr. Okonkwo (2001) 2 MJSC 67

However, of specific importance was the view of per Uwaifo JSC (as he then was) who held said that[184] he is completely satisfied that under normal circumstances no medical doctor can forcibly proceed to apply treatment to a patient of full age and sane faculty without the patient's consent, particularly if that treatment is of a radical nature such as surgery or blood transfusion. So, the doctor must ensure that there is a valid consent and that he does nothing that will amount to a trespass to the patient. Secondly, he must exercise a duty of care to advise and inform the patient of the risks involved in the contemplated treatment and the consequences of his refusal to give consent.

A necessary condition for informed consent is good communication between surgeon and patient.[185] When medical paternalism was normal, communication was relatively simple; it consisted of the surgeon's orders to the patient to comply with a particular treatment. Nowadays, communication requires much more from surgeons. They must provide patients with all the information they need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language. They should also ensure that patients understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision the patient has reached and, if possible, the reasons for it. Good communication skills do not come naturally to most people; they must be developed and maintained with conscious effort and periodic review. If the surgeon has successfully communicated to the patient, all the information the patient needs and wants to know about his or her diagnosis, prognosis and treatment options, the patient will then be in a position to make an informed decision about how to proceed. Although the term

[184]Ibid. also, Sideway vs. Board of Governors of Bethlehem Royal Hospital (1985) 11 A.C 871; also the South African case of *Esterhuizen vs. Administrator, Transvaal* 1957 (3) SA 710 (T) where it was held that a person of sound mind may refuse medical treatment irrespective of whether it would lead to his death or not.

[185] Manson, J.K & McCall Smith, R.A, *Law and Medical Ethics* (Butter Worths, London, 1991) 319; see also, Thomasma, D.C & Graber, G. C *Euthanasia: Toward An Ethical Social Policy* (Continuum, New York, 1990) 2.

consent implies acceptance of treatment, the concept of informed consent applies equally to refusal of treatment or to choice among alternative treatments. This is what the right to self-determination is all about. By this, the patient can exercise his or her right to self-determination by coming to the conclusion, whether to undergo the treatment or not.

3.15.0 CONCLUSION

This chapter has discussed the duties of a surgeon and the rights of surgical patients. It can be said that duties and rights are correlative to one another. While a surgical patient is entitled to some basic fundamental rights, a surgeon is under a duty to ensure the protection of such rights. It is from the violation and the breach of such rights that may result into the breach of the duties of a surgeon. Therefore, having examined all these, the next chapter analyses the legal frameworks that regulate a surgeon or a medical practitioner in the performance of his or her duties.

CHAPTER FOUR

LEGAL AND INSTITUTIONAL FRAMEWORK ON SURGICAL PRACTICE IN NIGERIA

4. 0.0 INTRODUCTION

The services rendered by medical profession to human beings are of high inestimable value. The practice of medicine involves various forms of interactions between the medical practitioners and the members of the public. Disputes occasioned by such interactions therefore become inevitable like many human endeavours. Disputes between the medical practitioners and the patients who are members of the public seem to be on the increase. This has resulted in numerous litigations and prosecution of medical practitioners. Sometimes, some members of the public seek self-help when they dispute with the health practitioners.

Undoubtedly, the law needs to play a critical role in regulating the practice of medicine in Nigeria, thereby reducing the incidences of conflicts between the medical practitioners and the public. Effective and justly balanced legal framework also requires competent institutions in order to ensure compliance through appropriate sanctions for the violators.

Therefore, this chapter is intended to analyse the adequacy or otherwise of the legal framework regulating the practice of medicine in Nigeria. Also, given the roles played by efficient institutions in ensuring compliances with legal provisions, the institutional framework for the practice of medicine will be examined in this chapter.

4.1.0 CRIMINAL LAW

Criminal law obviously applies to health care providers. One of the purposes of criminal prosecution is to punish the offender. There are two codes regulating criminal law in Nigeria. While the criminal code applies to the Southern States, the Penal code applies to the Northern

states. Both Codes contain similar provisions under which cases of surgical negligence may be charged. The focus will be on Criminal code.

Also, states have domesticated the codes to form criminal law in the states. Under the criminal code, any death that results from surgical negligence could be either murder or manslaughter.[186] Under the penal code, it could be culpable homicide punishable with death or culpable homicide not punishable with death.[187] This shows that a surgeon or any doctor may be criminally liable for an act or omission which has resulted into the death of a patient. This means that a medical practitioner (be it a doctor or a nurse) may be criminally liable if his negligence surpasses a mere matter of compensation as to amount to a crime against the state.[188]

In a situation where health-care providers in their practices become grossly negligent causing bodily harm, or reckless in the care of others, they will be liable in criminal proceedings. Both the criminal and penal codes provide sanctions for criminal negligence. For instance, Sections 303 & 343(1) (e) of the Criminal Code[189] is reproduced in this thesis- thus, that it is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to life or health of any person by reason of any omission to perform that duty.

[186] Criminal Code Act, Cap. C38, Laws of the Federation of Nigeria 2004
[187] Penal Code (Northern States) Federal Provisions Act, Cap P3, Laws of the Federation of Nigeria, 2004
[188] This is the legal position in the case of See *R vs. Bateman* (1925) 133 L.T. 30 at 732, (1925) 133 L.T. 30 at 732, in Okonkwo and Naish , *Criminal Law in Nigeria,* (Ibadan: Spectrum Books Ltd, 2003) p. 250
[189] Sections 303 and 343 (1) &(E) of the criminal code of Nigeria

On the other hand, Section 343(1) of the Code[190] provides that any person who in a manner as rash or negligent as to endanger human life or to be likely to cause harm to any person:

> (e) gives medical or surgical treatment to any person whom he undertakes to treat; or
>
> (f) dispenses, supplies, sells, administers, or gives away any medicine, or poisonous or dangerous matter; is guilty of a misdemeanour, and is liable to imprisonment for one year[191].

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

From the above provision, it can be said that criminal liability of a surgeon for a negligent treatment of a patient is envisaged in the law. The surgeon owes to the patient a duty of care. This duty must not be breached. This shows that where the degree of skill, care and competence required of a surgeon is not met in a particular case, a breach of duty which may

[190] Sections 343 (1) of the criminal code of Nigeria
[191] 343 (1) of the Criminal Code

give rise to criminal liability arises. The case of *Surgeon Captain C. T. Olowu vs. Nigerian Navy*[192] is illustrative here.

Apart from the above provisions, a surgeon could also be liable for murder or manslaughter depending on the circumstances of each case. This means that where a surgeon has negligently caused the death of a patient, such a surgeon may, upon conviction be sentenced to death or life imprisonment for manslaughter as the case may be. Therefore, if a health care provider does not use reasonable care, or his conduct falls below the standard of care required by law, he is said to be negligent. This implies that if a surgeon does not use reasonable care or he negligently performs his duties and thereby causes the death of a patient, he is guilty of manslaughter. However, his negligence or incompetence must be so great as to show a disregard for life and safety and to amount to a crime against the state and conduct deserving punishment. That is, the degree of negligence must be a gross one. The most frequently quoted statement on this aspect of the law is the dictum of Lord Hewart in the English case of *R. vs. Bateman*[193] where his lordship said, in explaining to the juries the test which they should apply to determine whether the negligence, in the particular case, amounted to or did not amount to crime, the judges have used many epithets, such as culpable, criminal, gross, wicked, clear, and complete. But, whatever, epithet be used, and whether an epithet be used or not, in order to establish criminal liability, the facts must be such that, in the lawyer's opinion, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disrespect for life and safety of human beings which could give rise to a crime against a state and behaviour worthy of punishment.

[192] Ibid
[193] (1925) 133 L.T. 30 at 732

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

As a result, the degree for liability, required of medical practitioner should be that of gross and not simple negligence. In ***Kim vs. State***,[194] the Supreme Court held that the degree of negligence required in the medical profession to render a practitioner liable for negligence is that it should be gross and not mere negligence. Also, the court cannot however transform negligence of a lesser degree into gross negligence by giving it that appellation. The court referred to and followed the case of *Akerele vs. R.*[195] Here, the accused, a qualified medical practitioner, administered injections of a drug known as Sobita to children as a cure for yaws. A number of children died and he was charged with manslaughter of one of the children. The case of the prosecution was to the effect that the accused had concocted too strong mixture and thereby administered an overdose to the deceased, amounting to gross negligence. He was found guilty of manslaughter and sentenced to imprisonment for 3 years. WACA upheld the conviction, but the accused further appealed to the Privy Council which held that the accused negligence did not merit to be gross negligence and appeal was allowed. The court reminded the counsel that what is required is for the negligence to be gross and neither the jury nor the court can transform anything lesser or higher about it.

[194] [1992] 4 NWLR (Pt. 233) p. 17
[195] [1942] 8 WACA 5

The use of criminal law in the medical context has been seriously questioned. For instance, it was argued that carelessness, incompetence and error should not, save in exceptional cases, be the business of the criminal law. However, it should be noted that since majority of offences arise from carelessness and error, there is nothing out of place using criminal law to regulate medical practice. This is because section 24 of the Criminal Code provides that no person can be criminally responsible for his unwilled acts or omission or express provisions of the Code relating to negligent acts or omission. This analysis shows that for a criminal conviction of manslaughter for a surgeon/or other medical practitioners to hold, there must be a gross negligence.[196]

The decision in the case of *Akerele vs. R*[197] represents the position in Nigeria. This decision is in line with Section 303 of the criminal Code which provides that every person, except in cases of necessity who undertakes to administer surgical or medical treatment, has a duty to have reasonable skill and to use reasonable care in administering the treatment. However, possible defences might be available in Sections 297 and 313 of the Criminal Code. Section 297 provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit if the performance of the operation is reasonable having regard to the patient's state at the time and to all circumstances of the case. However, if negative consequence has caused the death of the patient as a result of this breach of the duty to take care, a surgeon will be held to have caused such consequence.[198]

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

[197] [1942] 8 WACA 5

[198] The case of *Dr. Conrad Murray vs. Michael Jackson is a case in which* Dr. Conrad was found guilty of gross negligence in the surgery he performed on Michael Jackson the late famous musician, without reasonable skill and

It is trite law, therefore, that performing an emergency surgery in the absence of proper indications and justifications is negligence. An anesthetist was found guilty of manslaughter where he caused the death of a patient due to his gross negligence in attention during surgery.[199] Thus, a surgeon owes to his patient or client a duty of care not to act negligently. This is so whether or not there is an agreement between them. He must possess a reasonable skill and use the skill in every case. In the case of *R. vs. Inner South London Coroner,* ex p *Douglas-Williams,*[200] the Court was able to set out the requirements for a gross negligence. They are: (i) negligence consisting of an act or failure to act, (ii) that negligence must have caused the death in the sense that it was more than minimally, negligibly or trivially contributed to the death; and (iii) the degree of negligence has to be such that it can be characterised as gross in the sense that it was of an order that merits criminal sanctions rather than a duty merely to compensate the victim.

Similarly, sections 311 and 326[201] of the criminal code prohibit euthanasia (killing oneself) in whatever form(s) (either through the counseling of the surgeon, procuring or aiding it). See Terri Shiavo's case[202]. Section 311 provides A person who does any act or makes any

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care in performing the cosmetic operation which resulted to his death. The court of first instance found for Michael Jackson while both the Appeal Court and the Supreme Court confirmed the guilt in negligence.

[199] See *R. vs. Adomako* [1944] 3 All E. R. 78 (HOL, England). In this case, the defendant anesthetist failed to notice that a tube supplying oxygen to the patient (who had been paralysed for the operation) had become disconnected from a ventilator during an eye operation. The disconnection lasted for some six minutes without the notice of the anesthetist, and the patient suffered a cardiac arrest from which he subsequently died. Two expert witnesses gave evidence for the prosecution and one described the standard of care by the defendant as 'abysmal.' The other witness stated that a competent anesthetist should have recognized the signs of disconnection within 15 seconds, and that the defendant's conduct amounted to 'a gross dereliction of care. On this note, Lord Mackay stated that a finding of gross negligence would depend on the seriousness of the breach of duty committed by the defendant in all the circumstances in which the defendant was placed when it occurred.

[200] (1999) 1 ALL E.R. 344

[201] Section 311 & 326 of the Criminal Code of Nigeria.

[202] Terri Shiavo's case, Right to die (TI-TIII) 1990 – 2005, U.S.A The Terri Shiavo's case was a right to die case in the United States of America from 1990- 2005, involving Theresa Marie "Terri" Shaivo, (December 3, 1963- March 31, 2005. She was a woman in an irreversible persistent vegetative state. Shiavo's husband and the lawyer argued that Shiavo would not have wanted prolonged artificial life support without the prospect of recovery and elected to remove her feeding tube. But Shiavo's parents disputed her husband's assertions and challenged Shiavo's medical

omission which hastens the death of another person who, when the act is done or the omission is made, is laboring under the same disorder or disease arising from another cause, is deemed to have killed that other person. Equally, Section 326 says[203]: Any person who: (i) procures another to kill himself; or (ii) counsels another to kill himself and thereby induces him to do so; or (iii) aids another in killing himself; is guilty of a felony; and is liable to imprisonment for life.

The combined effect of the above provisions shows that aiding a patient towards killing himself is illegal in Nigeria and no surgeon has a right to terminate the life of any patient or help to terminate the life of a patient. Where he does, he will be liable to criminal prosecution which may attract life imprisonment or death sentence.

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

4.2.0 THE CONSTITUTION

The Constitution of the Federal Republic of Nigeria is the supreme law.[204] In fact, it is the grund norm through which all other laws derive their validity.[205] The implication of this is that any law which is inconsistent with the constitutional provisions shall be null or void to the extent of its

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diagnosis, arguing in favour of continuing artificial nutrition and hydration. The highly publicized and prolonged series of legal challenges presented by her parents, which ultimately involved the state, the Federal politicians up to the level of the president of U.S.A. then, George Bush, caused a seven-year delay before Shiavo's feeding tube was removed. This was after several appeals and counter appeals both at the Appeal Courts and the Supreme Court of U.S, until Judge Greer ruled that the tube should be removed and allow Shiavo to rest in peace.

[203] Section 326 of the Criminal Code of Nigeria.
[204] See section 1(1) of the Constitution of the Federal Republic of Nigeria, (CFRN) 1999 As Amended.
[205] Ibid.

inconsistency.[206] It is true that there are no explicit provisions on the rights of a patient in the constitution. However, some basic rights by implication can be expounded to protect a patient. For instance, the constitution in chapter 4 has made ample provisions for some basic or fundamental rights. Some of these rights have direct link with the protection of a patient. Examples of these are: right to protection of human dignity, right to liberty and right to self-determination.

4.2.1. Right to protection of human dignity

From Section 17(3) of the 1999 Constitution of the Federal Republic of Nigeria (CFRN, 1999) (as amended) dealing with social objectives which obligates the Nigerian government to direct its policies by ensuring that adequate healthcare facilities reach to all persons. It is recognised that it is the responsibility of the government to ensure the mental and physical good health of its citizenry and protection of its human dignity[207]. Although the above section 17 of the Constitution appears not justiciable,[208] the justiciability of human dignity is upheld under Section 34 of the Constitution.

It is submitted that human dignity (Section 34) is difficult to realise without healthy human beings. This is because the human person cannot be said to be complete without a healthy body. In view of this, it has been argued that the sincerity of the government in its attainment of health for all by the year 2000 and 2020 is not tenable. For instance, Atsenuwa and Ezeilo shared their views towards the 1999 Constitution of the Federal Republic of Nigeria about not recognizing the right to health of its citizens directly even though the author alluded to the rights in some provisions as mentioned above.

4.2.2. Right to Personal Liberty

[206] Ibid.
[207] Section 17(2)(b) CFRN 1999.
[208] Section 6(6)(c) CFRN 1999.

The right to personal liberty is provided for under Section 35 of the 1999 Constitution of the Federal Republic of Nigeria to its citizens. Section 35(1) (e) applies more to the practice of medicine. It creates an exception to the liberty of a person to situations where such persons suffer from infectious or contagious diseases, persons of unsound mind, persons addicted to drugs or alcohol for the purpose of the patient's care or treatment or protection of the community.

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

Furthermore, even in the area of restricting the liberty of a patient for treatment and care in the interest of the community, it is only the Federal government that has the power to quarantine such patient. States do not have such powers as it is contained in exclusive legislative list of the federal government of Nigeria.[209]

More so, the guaranteed right to personal liberty may cause problems for the practice. This is particularly the case in Nigeria's current security situations where kidnapping seems to be prevalent. So, a surgeon, whose patient is kidnapped in his hospital, may render himself liable in negligence or conspiracy to commit an offence under the law. Thus, the law does not provide for any special protection to medical practitioners in this regard. While the researcher is not attempting to provide a wide enjoyment of liberties to the medical practitioners to be careless about patient's right to liberty, the law should balance this situation to protect the practitioners from unwarranted litigations or prosecutions. More so, the practitioners can themselves be kidnapped in the course of their duties, thereby affecting their own right to personal liberty. This

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

calls for the surgeon's diligence and alertness in his care for his patients by ensuring adequate surveillance, supervision and protection of his patients. Any surgeon, who falls short of this duty of care, is likely to end up in litigation for negligence or prosecution for conspiracy to commit an offence to wit-kidnapping.

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

As a result, the Nigerian state which is still ravaged by staggering number of preventable deaths and plagued by different diseases which have been successfully tamed in many countries, where the health of the citizens is considered paramount, may continue to have more deaths. Jide Ojo, a Development Consultant, lamenting on the poor health situation in Nigeria, gave what he termed a dreadful score card and he said Almost 800,000 Nigerian children die every year before their fifth birthday, making Nigeria the country with the highest number of new born deaths in Africa. An estimated 500,000 women die each year throughout the world from complications of pregnancy and child birth; 55,000 of these deaths occur in Nigeria. Nigeria is only two percent of the world's population but accounts for over 10%[210] of the world's maternal deaths in child birth and ranks second globally to India in number of maternal deaths.

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

4.3.0 MEDICAL ETHICS

Many professions in the world, be it trade, calling, vocation, and so on, have its own ethics which vary from one to the other, even though they exist to serve the same purpose, namely, to regulate the practice of the profession. The essence and value of ethics in every discipline cannot be quantified, particularly in medical practice where continuous advancement in research in technology has rapidly developed. Another reason why ethics is important in medical practice is the fact that medical practitioners deal with human being's life which is precious and sacred and when it is lost, cannot be reversed. So, it is expected that those who deal with life should mandatorily have a code of conduct guiding them.[211]

Ethics is derived from the Greek word meaning ethos. This simply means morality and good conduct. It is a system of accepted beliefs which control behavoiur.[212] It connotes moral principles of conduct and simply means a code of conduct. As it relates to medical practice, it means guiding and regulating the practice of medicine which members voluntarily agree to observe. Ethics is a code of behaviour accepted voluntarily within the profession, as opposed to statutes and regulation imposed by official regulation.[213]

Following the above definitions, it can be seen that ethics is no more than a set of rules of conduct distinguishing what is right from what is wrong. As expected, all rules of conduct have a semblance of all penal legislations which regulate human conduct. They share the same ground of commonality with a given legislative provision and where this happens, it means a breach of

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[211] Oxford Advanced/Learner's Dictionary, 5th Ed. Ethics, also known as moral philosophy, is a branch of philosophy that involves systematizing, defending and recommending concepts of right and wrong conduct. See http://wwiep.utm.edu/ethics/; http://en.wikipedia.org/wiki/Ethics. Hence, ethics can come in various forms and types e.g meta-ethics, normative ethics, applied ethics (such as bioethics, geo-ethics, business ethics, relational ethics, machine ethics, military ethics, political ethics, public sector ethics etc) evolutionary ethics, descriptive ethics etc.

[212] See See also Fadare J.O Desalu O .O, Jemiloun A. C, Babatunde A.O "Knowledge of Medical Ethics among Nigerian Medical Doctors" *Niger. Med. J. (Serial online) 2012, 53:* 226-30. Available from: http://www.Nigeriamedj. Ong W.Y, Yee C.M, Lee A, "Ethical Dilemmas in the Care of Cancer Patients near the End of Life" *Singapore Med. J. 2012, 53:11-6.*

[213] Ibid.

such code is condemnable by both profession and the general law. However, the fact that there is no corresponding legislative provision on a particular code of conduct does not weaken the efficacy of such a code.[214] Consequently, the medical ethics function, in essence and focus can be captured in three Rs, namely: (i) to restrict, (ii) to rule, and (iii) to regulate.

The medical ethics restrict because they circumscribe practitioners by limiting them, they rule because they direct and prescribe what can be done and they regulate because they stipulate standards which practitioners must observe and conform with. It should be remembered here that most of the rules are not written while some were written. But, whether they are written or unwritten, the import is the same and as such the efficacy of a code of conduct is not really minimised or undermined simply because such ethical standard is not reduced into writing.

The last preliminary point to be made here is that ethics consists of good manners and civilised behaviour in general. So, in all cases, the overriding consideration is the welfare of the patient. There is a fundamental reason why societies develop rules to govern behaviour. This is for social cohesion which allows a group to work together for identifiable common aims. This is absolutely fundamental to the development of a profession which, by definition, is a group of individuals who have, and act on a common body of knowledge. The group develops its own internal rules which govern behaviour and form the basis of their professional ethics.

The Medical and Dental Practitioners Act 1990 (Decree No. 23 of 1988)[215] now LFN 2004 .provides for the establishment of the Medical and Dental Council of Nigeria hereinafter called the Council. Section 1 Subsection 2 (c) of the Act provides for the statutory functions of the Council principal among which is reviewing and preparing from time to time a statement as

[214] See The Journal of Medical Ethics (BMI Journals) a leading international journal that reflects the whole field of medical ethics. jme.bmj.com. see generally www. bma.org.uk/ethics/index.jsp. Medical Rehabilitation Therapists have their own ethics. See the Medical Rehabilitation (Registration) Act Law of Federation of Nigeria, 2004 which provides for disciplinary measures for ethical breach by members.

[215] (1990) Medical and Dental Practitioners Act (Decree No. 23 of 1988) Now LFN 2004

to the code of conduct which the Council considers desirable for the practice of the profession in Nigeria

Section 2 (d) (e) of the Medical and Dental Practitioners Act[216] empowers the Medical and Dental Council of Nigeria to oversee, control and supervise the practice of customary medicine, homeopathy and other kinds of alternative medicine in Nigeria. Pursuant to the enabling law, the Medical and Dental Council of Nigeria has been constituted in accordance with the provision of the law. The statement on the Code of Conduct which the Council considers desirable for the practice of the profession in Nigeria has been prepared and reviewed from time to time. It was first titled Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria but later titled CODE in consonance with its legal status.[217]

The Council wishes that every Medical and Dental Practitioner should acquaint himself or herself with the provisions of the Code so that he or she would practise the profession with conscience, dignity and within the provisions of the Code. This will bring incidences of ethical breaches or violations to the barest minimum as ignorance of law admits no excuse. Compliance with the code will enhance the image of the profession; increase the confidence of the public in the practitioners and offer protection to the conscientious practitioners.

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

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[216] Medical and Dental Council of Nigeria to Oversee Control and Supervise the practice of customary Medicine
[217] www.mdcnigeri .org/Downloads/CODE .

Part A of the Code contains Sections 1-24 which deals with preamble and general guidelines, which include: the objective of the rule, induction of newly qualified medical or dental practitioners into the profession, Declaration and Oath, Registration, payment of practicing fees and annual license, guidelines for non-indigenous medical and dental practitioners, clinic etiquette, self-medication by registered practitioners, professional services to colleagues, telemedicine, management of HIV/AIDS and other socially dreaded diseases.[218]

Part B of the Code contains Sections 25-31which deal with professional conduct, professional brotherhood of good repute and competency, professional negligence and so on.[219] Part C of the Code contains Sections 32-39 which deals with malpractices in general respect, deceit of patient to extort fees and service charges, aiding and abetting unprofessional practice of medicine and dentistry and so on.[220]

Part D of the Code contains Sections 40-48 which deals with improper relationship with colleagues or patients, instigation of litigation, case referrals to colleagues, movement of patients among practitioners, confidentiality and adultery or other improper conducts or association.[221]

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

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

[218] www.mdcnigeria.org/ethical%2520cond also www.mdcnigeria.org/mandateframe.htm.
[219] Ibid.
[220] Ibid.
[221] Ibid.

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

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

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

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

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

4.4.0 HIPPOCRATIC OATH (THE ORIGINAL VERSION)

I swear by Apollo the physician, and Asclepius, and Hygieia and Panacea and all the gods and goddess as my witnesses, that, according to my ability and judgment, I will keep this Oath and this contract:

To hold him who taught me this art equally dear to me as my parents, to be a partner in life with him, and to fulfill his needs when required; to look upon his offspring as equals to my own siblings, and to teach them this art, if they shall wish to learn it, without fee or contract; and that by the set rules, lectures, and every other mode of instruction, I will impart a knowledge of the art to my own sons, and those of my teachers, and to students bound by this contract and having sworn this Oath to the law of medicine, but to no other.

I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

In purity and according to divine law will I carry out my life and my art.

I will not use the knife, even upon those suffering from stones, but I will leave this to those who are trained in this craft.

Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seethe seduction of women or men whether they are free men or slaves.

Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.

So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate.

Prospective Medical and Dental Practitioners being inducted to practise in Nigeria are required to publicly declare their readiness to obey professional rules and regulations thus[222] I, Dr. XYZ do solemnly and sincerely declare that as a registered medical/dental practitioner of Nigeria, I shall exercise the several parts of my profession to the best of my knowledge and ability for the good, safety and welfare of all persons committing themselves to my care and attention and that I will faithfully obey the rules and regulations of the Medical and Dental Council of Nigeria and all other laws that are made for the control of the Medical and Dental profession in Nigeria.[223]

In addition to the Declarations mentioned above, the Medical and Dental Practitioners in Nigeria are made to subscribe to the PHYSICIAN OATH[224] which is reproduced as follows:

> *I (Dr) XYZ SOLEMNLY PLEDGE to consecrate my life to the service of humanity;*
> *I WILL GIVE to my teachers the respect and gratitude which are their due;*
> *I WILL PRACTICE my profession with conscience and dignity;*
> *THE HEALTH OF MY PATIENT WILL BE my first consideration;*
> *I WILL RESPECT the Secrets which are confided in me even after the patient has died;*

[222] Ibid.
[223] The original Hippocratic oath of the doctors www.mdcnigeria.org/Downloads/CODE
[224] MDPN-Declaration of Hippocratic Oath. (physician Oath, adopted by the General Assembly of World medical Association (WMA) at Geneva , Switzerland in August, 1994 and amended by the world Medical Assembly at Sydney in Australia, in Augusts, 1994.

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

The foregoing is also referred to as the Declaration of Geneva (Physician Oath Declaration) adopted by the General Assembly of World Medical Association at Geneva, Switzerland in September 1948 and amended by the 22nd World Medical Assembly at Sydney Australia in August 1994.[225]

The above Physician Oath is the modern version of what is popularly called the Hippocratic Oath which is the foundation of the code of medical profession.[226] The signature of the doctor or dentist taking oath is appended and it is also dated appropriately. Every medical practitioner in Nigeria is thus expected to be guided by the code of professional ethics as complemented by the combinations of the Declaration and the Physician Oath in the performance of his professional responsibilities. Every member of the medical profession must abide by the dictates of the physician's oath. Embodied in this oath are the guidelines for behavioural interaction between practitioners and their patients; practitioners and their teachers; as well as practitioners and the public as represented by the law and the government.[227]

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

[225] www. medterms.com/script/main/art.asp
[226] Hippocrates 1760-337, a Greek man and the greatest physician of antiquity regarded as the father of medicine Hippocratic Oath is the Physician Oath of today.
[227] www.britannia .com/./ Hippocratic-oath

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

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

4.5.0 CONSUMER LAW TO MEDICAL PROFESSION

Consumer Protection Act, 1986 was enacted by the parliament to provide for better protection of the interest of the consumers in the background of the guidelines, contained in the Consumer Protection Resolution passed by the United Nations General Assembly on 9th April, 1985. The legitimate needs which the guidelines intend to meet include – protection of consumers from hazards to their health and safety and availability of effective consumer redress.

4.5.1. *Consumer Protection*

Accordingly, the consumer protection Act, 1986, is to provide protection and relief to persons who have hired any services for consideration when the services provided are found to be suffering from deficiency in any respect[228]. According to the Apex Court, a determination about deficiency in medical service is to be made by applying the same test as is applied in an action for damages for medical negligence[229].

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[228] Consumer unity and Trust Society, Janipar vs. State of Rajasthan 1991 (I) CPR, 241 (NC) 1 (1992) CPJ 259 (NC) (1993)1 CTT 89 (NCDRC).

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

Since the very purpose for which the statute was enacted is to provide a cheap and speedy remedy to the aggrieved customers by way of an alternative to the time consuming and expensive process of civil litigation, the consumer forum cannot refuse to adjudicate the dispute regarding deficiency in service rendered by medical practitioners for consideration[230].

The Consumer Protection Act, 1986 is another legislation that has influence on the medical profession with regard to monitoring the activities of the surgeons/other medical practitioners. The Nigerian Consumer Protection Act 1992 established the Consumer Protection Council and the various committees with the mandate of carrying out the functions under Section 2 of the Act. Some of the functions include, but not limited to, the following:

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

(ii) The council is to seek ways and means of removing from the markets hazardous products and causing offenders to replace such products with safer and more appropriate alternatives. In the exercise of the above provisions, the council has power, amongst others to;

(a) Apply to the court to prevent the circulation of any product which constitutes public danger or imminent public hazard;

(b) Compel manufacturers to certify that all safety standards are met by their products; and

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

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

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

The issue here is whether the Consumer Protection Act in Nigeria covers the medical service? The objective of Consumer Protection Act (CPA) was to provide speedy and simple redress to consumer disputes. By its provision of a wider access to the justice system through speedy procedure, absence or nominal court fees and adequate compensation, this Act has thus revolutionised the system of justice and made it favourable to the consumer. With the ever increasing public awareness about their rights, the patients too as consumers now insist on getting their money's worth in terms of quality health care.

Section 2(1)(0) of the CPA provides that the word Service means service of any description that is made available to any potential users and includes but not limited to, the provision of facilities, in connection with banking, financing insurance, transport processing, supply of energy or electrical, housing construction, entertainments and so on.

It may be appropriate here to mention that whereas CPA has been made applicable to all goods and services, two types of services have categorically been kept out of the purview of this Act. These are services rendered free of charge and service rendered under a contract of personal service. The contract of personal service has been debated a lot of times before the consumer specialists for and in a number of cases. For example, in an Indian case, *Justice vs. Bala Krishna*[231] *Era,* President, National Consumer Disputes Redressed Commission (NCDRC), delivered a land mark judgment in *Cosmopolitan Hospital and Anor vs. Vasantha.*[232] *P. Nair.* in this case, held that the activity of providing medical assistance for payment carried on by the hospital and members of the medical profession, falls within the scope of the expression service as defined in Section. (1)(0) of CPA. Thus, in the event of any deficiency in the performance of such service, the aggrieved party could invoke the remedies provided under the Act by filing a

[231] (NCDRC). (1994) 2 CTJ 97(CP)(NCDRC): 1994(2) CPR 488 (NC) affirming decision of State Commission
[232] (1991) (2) CPR 155 (Ker) 11 (1991) CPJ 144

complaint before the Consumer Forum having jurisdiction. It has also been held that legal heirs of the patient/s who were undergoing treatment in the hospitals are consumers under the Act and were competent to make their own complaints.

In another development, in *Indian Medical Law Association vs. V.P. Shantha's*[233] *case*, Mrs. Pat had a hysterectomy (operation to remove the uterus) and repair of umbilical hernia by a gynecologist, assisted by other surgeons, the patient filed a case before the Consumer Court alleging medical negligence by the surgeon, and wanted to join the other surgeons who assisted the surgeon. The court refused to join the other surgeons but held that it is the sole responsibility of the principal surgeon who was held liable. The Supreme Court of India concluded in that case that it is no doubt true that the relationship between the surgeon/medical practitioner and a patient carries with it certain degree of mutual confidence and trust. Therefore, services rendered by the medical practitioner can be regarded as services of personal nature. However, since there is no relationship of master and servant between the doctor and the patient, it cannot be treated as a contract of personal service. Nonetheless, it is a contract for services and the service rendered by the medical practitioner to his patient under such a contract is not covered by the exclusionary part of the definition of service contained in Section 2(1)(0) of the Act. However, the Supreme Court was able to resolve the heavy criticisms and controversies that the judgment generated and expressly gave guidelines in the landmark judgment to determine which services are covered and which are excluded. It concluded that, however, broadly speaking, the medical services are covered under the provisions of the Act if they are not free services.

The Nigerian Consumer Protection Act equally has a similar provision to that of India in trade, merchandise, commerce and others but has no provision for medical services. This, to some extent creates legal uncertainty as to its applicability to the service rendered by legal

[233] (AIR 1996) SC 550

practitioners. The Act, therefore, needs to be amended to cover the situations of surgeons/patient relationship in line with the guidelines provided by the Supreme Court of India. In the meantime, courts in Nigeria can be persuaded by the decision of the courts in India pending the amendment.

4.6.0 INSTITUTIONAL FRAMEWORKS ON MEDICAL PRACTICES IN NIGERIA

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

4.6.1 Medical and Dental Council of Nigeria[234]

The primary medical regulatory body in Nigeria is the Medical and Dental Council of Nigeria (MDCN). It is a statutory regulatory body set up by law. Its stated purpose is to regulate the practice of Medicine, Dentistry and Alternative Medicine in the most efficient manner that safeguards best healthcare delivery for Nigerians. The Act (Medical and Dental Practitioners Act Cap 221 [now Cap M8] Laws of Federation of Nigeria 2004 sets up the MDCN[235] and charges the council with the following responsibilities:

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

[234] Up Cit
[235] Supra

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

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

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

• *The Red Book: Guidelines on the Minimum Standards of Medical and Dental Education in Nigeria*

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

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

The implication of the above is not to impose curriculum on the medical schools. Rather, it is meant to follow the broad guidelines laid down by the council in specific areas such as the subject matter, which the curriculum may cover, and the minimum length of time which the

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

4.6.2 Medical and Dental Practitioners Disciplinary Committee/Tribunal

Section 15 of the Medical and Dental Practitioner's Act (MDPA), 2004 established the Disciplinary Tribunal with the duty of considering and determining any case referred to it by the Panel. The membership of the Disciplinary Tribunal is made up of the chairman of the Council and ten others. The disciplinary power of the Tribunal over medical practitioners and dental surgeons is undoubtedly very important and viable power of the Council. It is a very important function because of the high premium placed on the maintenance and promotion of professional discipline and etiquette of the profession. The disciplinary measures are exercisable over erring registered medical practitioners and dental surgeons. Section 16 of the Act provides for three broad instances in which the Council, through the Tribunal, will invoke its disciplinary powers. These are:

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

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

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

(i) It can order the Registrar to strike out the name of the erring practitioner from the register;

(ii) It can suspend the person from practice for a period not exceeding 6 months; and

(iii) It can admonish the person.

A person whose name is removed from a Register in pursuance of direction of the Disciplinary Tribunal under this section shall not be entitled to be registered in that Register again except in pursuance of a direction in that behalf given by the Disciplinary Tribunal on the application of that person. There were number of cases where the tribunal has found some medical practitioners guilty of infamous conduct. For instance, In the case of *Olaye vs. Chairman, Medical & Dental Practitioners Disciplinary Tribunal (MDPDT),*[236] *in this case, the* appellants and three other medical practitioners were charged before the Disciplinary Tribunal for negligence by *their non-attendance to a patient contrary to the ethics* of the medical profession. Though the appellant denied liability, the tribunal found him liable and directed that his name be struck off the Register of Medical and Dental Practitioners in Nigeria. The Nigerian Court of Appeal allowed the appellant's appeal on mere technical ground of non-observance of rules of natural justice by the tribunal.

In the Nigeria case of *Denloye vs. Medical & Dental Practitioners Disciplinary Tribunal (MDPDT),*[237] Denloye was charged with neglecting in a prolonged manner between 29th June 1966 and the 10th July 1966 a patient very seriously ill, extortion of the sum of 30 guineas from

[236] (1977) NMLR pt 506 P. 550
[237](1968) 1 All NLR 306.

the patient's father as an inducement for him to treat the patient among other allegations. The Tribunal pronounced him guilty of infamous conduct in a professional respect and ordered the removal of his name from the Medical Register. On final appeal to the Supreme Court of Nigeria, it set aside the decision of Tribunal also on technical ground of non-observance of rules of natural justice.

In *Akintade vs. Chairman, Medical & Dental Practitioners Disciplinary Tribunal (MDPDT),*[238]Court of Appeal held that the term infamous conduct include, failure to attend to patient promptly, incompetence in the assessment of the patient, deficient treatment arising from inadequate pre-operative investigation, deficient operative procedure and poor and faulty post-operative management.

In *Alakija vs. Medical Disciplinary Committee,*[239] the committee ordered the removal of Alakija's name from the Register of Medical Practitioners for two years. The Supreme Court of Nigeria[240] later quashed the decision on technical grounds of non-observance of rules of natural justice. In the case of *Okezie vs.* Chairman *Medical & Dental Practitioners Disciplinary Tribunal (MDPDT),*[241] Dr. Okezie, a Registered Specialist Obstetrician and Gynecologist and a Lecturer at University of Nigeria Teaching Hospital, Enugu was found guilty of infamous conduct and gross professional negligence in 2001. He was suspended from practices for six months for losing his patient **(**Mrs. Obiekwu) after a caesarian operation. The charges against him include negligent failure to secure the professional services of an anesthetist and also of qualified registered nurses to provide necessary professional care as required before, during and after the caesarian operation; failure to provide cross-matched bloods and oxygen which would

[238]**(**2005**)** 9 NWLR (pt. 930) 338 p.5
[239] (1959) FSC 38
[240] Ibid
[241] (2010) 26 WRN

have been used to resuscitate the patient at the time of impending respiratory failure which eventually set in post operatively; operating at an unregistered institution known as Christian Miracle Hospital. About 10 years later, the Court of Appeal set aside the Disciplinary Tribunal's decision of the Disciplinary Tribunal for non-observance of the law of natural justice.

What could be deduced from the foregoing Nigerian case laws is that while the professional tribunal in Nigeria has been very justifiably strict on reported cases, reported for ethical breaches of members, the Nigerian courts have been more liberal than the Tribunal in the approach to ethical breaches.

4.6.3 The Investigating Panel

Section 15 (3), of the Act which established the Investigating body (MDPA)[242], is charged with the following duties:

(i) conducting a preliminary investigation into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner and or a dental surgeon, or should for any reason be the subject of proceedings before the disciplinary tribunal;

(ii) compelling any person by subpoena to give evidence before it's decision, if satisfied, that to do so is necessary for the protection of members of the public, to make an order for interim suspension from the medical or dental profession in respect of the person whose case they have decided to refer for inquiry, and for the case to be given accelerated hearing by the disciplinary tribunal within three months; or

(iii) deciding, if satisfied, that to do so is necessary for the protection of members of the public or is in his interest, to make an order for interim conditional registration in respect of that person, that is to say, an order that his registration shall be conditional on his

[242] Section 15 (3) of the Medical and Dental Practitioners Act 2004

compliance, during such period not exceeding two months as is specified, as the panel may think fit to impose for the protection of members of the public or in his interest.

(iv) the Investigating panel is made up of 15 members appointed by the Council among who must be three dental surgeons.

The legal and practical implication of the above provisions is that before a medical practitioner who is found wanting and punished for any offence of infamous conduct, the investigating panel must, first, have investigated the alleged offence of infamous conduct before referring the issue to the Disciplinary Tribunal, who would equally conduct its own investigation into the case. Where a medical practitioner had been found guilty by the Tribunal, the Tribunal may, if it thinks fit, direct that the name of the practitioner be erased from the Register or that his registration be suspended for a period not exceeding six months or simply admonish him/her.

4.6.4 Nigeria Medical Association

The NMA has been a long time association of all medical doctors and dentists. It shares the same objectives as the MDCN, as stated in the Codes of Ethics and Conduct. It commands the allegiance of all doctors and dentists in the land. It is the largest medical association in the West African sub-region. It has over 35,000 members from 36 state branches and the branch from the Federal Capital Territory. About 70% of the doctors associated with the NMA practise in urban areas where only 30% of the Nigerian population resides.[243]

The governing body of the NMA is the NOC and National Executive Council. It has powers to act on its behalf in the period between the Annual Delegates' Meetings in accordance with the Constitutional provisions of the Association. Referring to Act of the Medical and Dental Practitioners, any registered medical and dental practitioner has the right to become a member of

[243] International Comparison of Ten Medical Regulatory Systems retrieved from http://www.gmc-uk.org/International_Comparison_of_Ten_Medical_Regulatory_Systems___final_report.pdf_25404378.pdf [accessed on the 21st November, 2016]

the Association on payment of the annual fee. There are six main categories of members: ordinary members, life members, honorary members, associate members, student members and distant members.[244] However, it is only formally consulted by the government on an ad-hoc basis and it has to press for its participation. At present, the NMA is not only involved in influencing health policy formulation in an ad-hoc manner. It plans to be more explicitly involved in all aspects of policy formulation, especially in the planning stages, and is currently and actively involved in talks with the federal Ministry of Health to make this happen.

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

4.7.0 CONCLUSION

It can be said from the foregoing analysis that the legal framework is weak and not adequate enough to regulate the practice of medicine in Nigeria. The criminal laws contain some uncertainties as it merely provides for liability or prosecution for medical negligence. It does not provide for a clear degree of negligence necessary to be held liable. As a result, courts are left with conjecture or use of wide discretion in determining the degree of negligence. Decisions of courts from other jurisdictions are merely of persuasive effect in our criminal jurisprudence. In the same token, the constitution does not provide for a justiciable right to health. The other related rights as it affects medical practice are either too wide or too narrow as pointed out in this study. Also, medical practice, like many other professions, has its institutional frameworks which regulate the profession. Through its disciplinary committee, it disciplines its erring members. The law establishing the association empowers it to discipline and sanction its erring members. It

[244] Ibid.

is this ability to sanction erring members that has helped to ensure maintenance of high standards in medical practice in Nigeria. Being mindful that somebody somewhere is observing the activities (of the surgeons/any medical practitioner) and being aware of this fact that the association can discipline members who have carried out their duties in an unprofessional manner, reduces incidences of professional negligence.

CHAPTER FIVE

JUDICIAL ANALYSIS OF SURGEONS' LIABILITIES

5.0.0. INTRODUCTION

Activities of surgeons in theatre room require high level of experience, expertise and care. The reason is that operating on patients in the hospital carries with it a lot of positive and negative possibilities. Sometimes, unexpected and unintended circumstances such as complications occur in the course of operation. Yet, managing the situation may sometimes depend on the level of expertise, experience and competence of the surgeons. So, in some instances, the patients or their relatives feel aggrieved with the management of the situation. Actions are, in some cases, brought to court for redress.

Against the above backdrop, this chapter will, therefore, analyse the liabilities of surgeons through judicial analysis. To achieve this objective, the chapter will discuss the nature, stages and various types of liabilities that may be incurred by the surgeons.

5.1.0 LIABILITIES OF SURGEONS

Liabilities of surgeons could arise pre-operatively, during the operation and post-operatively. These stages of liabilities can be sub-zoomed into the various types of liabilities namely: (i) tortious or civil liability which includes primary and vicarious liability; and (ii) Criminal liability.

5.1.1 Tortious liability

Tortious liability can arise in case of negligence of a surgeon treating a patient. This liability is meant to serve two main purposes. Firstly, it provides compensation to those injured as a result of negligence, thereby acting as a source of insurance. Secondly, it serves as a deterrence that

will prevent future occurrence of the negligence. The tortious liability is usually a civil action brought by the patient or his heirs. Tortious liability can either be primary or vicarious.

A vicarious liability should not be confused with primary liability of hospitals. Apart from vicarious liability, a hospital may commit a breach of duty of care, which it owes to another, i.e. a hospital may be in breach of its own duty to another. An example of this is where a hospital is at fault for selecting an unskilled person as its staff who conducts himself in a wrongful manner, or allowing such a person to continue in employment; or where it provides defective equipment for use by the health care team under its employment.[245]

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

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

identify which one or more of the team of surgeons, anesthetists, nurses, and so on, are involved in the operation, was careless. It was held in *Cassidy vs. Ministry of Health*[246] that, in such a situation, the hospital authority will be vicariously liable, unless it can show that there was no negligent treatment by any of its servants. It is usually better for an injured plaintiff to join the hospital (master) as a defendant because; it is richer than any of its servants and will be in a better position to pay than the servant (provider).

5.2.0. DAMAGES

This constitutes the last very important ingredient of negligence which must be established before a plaintiff can succeed in a claim in negligence. No matter how negligent a surgeon might be, a patient cannot successfully institute an action against him/her if he did not suffer any damage. By damage here we mean a loss or injury that can be measured and compensated for in terms of money. A good example of such loss is given by Bernard Knight as follows:[247].

1) Loss of earnings whether due to enforced absence from work or prevention or impairment of his ability to carry on his previous occupation, so that he is forced to take employment at a lower level of salary.
2) Expenses accrued because of the damage caused by the negligence, which may be hospital bills, nursing bills, special treatment, special food etc.
3) Reduction in expectation of life apart from the financial aspect.
4) Reduced enjoyment of life from any physical or mental consequences of the negligent act e.g. loss of a limb, faculty or sense which would reduce mobility or appreciation of his surroundings.

[246]*Cassidy vs. Ministry of Health* [1951] 2 K.B. 343.
[247] Bernard, op cit a 19 - 20

5) In the case of women, some physical disability or disfigurement which might reduce the chances of marriage or inability to have children - these are actionable.
6) Pain and suffering whether physical or mental may also be taken into account such as mental or nervous shock.
7) Death may be actionable for the benefit of dependent relatives. The main criteria applied to measure such damages is the loss of potential future earning power, off – setting by life insurance, pension, all being taken into account.

All damages awarded for items such as loss of faculty, pain and suffering, loss of expectation of life among others are termed general damages while damages awarded for expenses such as medical and nursing attention are termed special damages. While general damages depend on the assessment of all the factors obtained in the particular case by the judge, special damages on the other hand are liquidated sum capable of being completed exactly.

5.3.0. PROOF OF DAMAGES/BURDEN OF PROOF

There is a general belief that the burden of proving negligence rests with the plaintiff. This confirms the saying that who asserts must prove. This means that when all the evidences are put together on the balance, and shown that the defendant was not negligent, it then means that the plaintiff will fail in his/her action. The plaintiff is the one who has suffered the harm or the injury which she/he has claimed was as a result of the carelessness or negligence of the defendant. If he or she is not able to establish the relevant facts in issue, his/her case will fail.[248]

This trying to establish the relevant fact in the issue may be a bit difficult especially if the plaintiff is a lay man who has no idea of science of medicine or surgery. Again, he may not even

[248] Overseas Tankship (UK) Ltd vs. Miller

know what has happened to him/ her especially if the injury or harm happened during operation when he/she was under a sedation. He may need to call in an expert witness which is very difficult for him. This is because no doctor or nurse or even the anaesthetist would come to witness or any of those who participated in the operation of the patient. So, this would be a very big task for him and a big burden to prove, what in fact might be a valid claim of the defendant. Most importantly, is the fact that the judge would rely on the expert witness to draw his conclusions. This was what happened in the case of *Mrs. Ojo vs. Gharoro & Anor & UBTH*[249].

The plaintiff may be always in a fix to prove what is required of him which he cannot have what it takes to prove. Those obstacles are what the surgical patients complained of during this study that hinder them from prosecuting surgical negligence. They equally complained that their fellow health care team would not want to testify against themselves. This means that justice would not be obtained at the end of the day while the plaintiff will walk away miserably without any remedy whatsoever. Often times, the plaintiff would not be able to locate the actual problem except in the case of an accident, what we call *Res Ipsa Loquitor* which means that the thing speaks by itself. It is only then that justice may be given. This is a Latin maxim which suggests that what has happened is seen by everybody and does not need any explanation any longer.

This maxim was also explained by Erle C. J. in Scott vs. London and St Katharine Docks Co.[250] where the learned Justice said that where it is shown that the thing is under the management of the defendant or his servant, and the accident is such that in the ordinary course of things does not happen, if the management had used proper care, it will afford a reasonable

[249] Supra
[250] (1865) 3 H & C 596, Osuigwe vs. Unipetrol (2005)5 NWLR (Pt98) 261

evidence not minding any explanation to the accident, even in the absence of the defendant. This means that if the patient can show that what actually caused the damage to him/her is in total control and management of the defendant or servants, that accident could have been prevented if the defendant had used a reasonable care, the plaintiff would succeed. The court would definitely find for the plaintiff if such happens. This means that the plaintiff would no longer be asked to prove negligence since all the surrounding circumstances suggest negligence.

What the Maxim of *Res Ipsa Loquitor* actually means is that the plaintiff does not know what caused the damage but people can see for themselves the cause of the damage. That was exactly what happened in the case of *Igbokwe vs. University College Hospital, Ibadan,*[251] where a lady who just had a baby and was diagnosed psychotic jumped from the 4th floor of the building to the ground and died. A nurse was supposed to have been with her but she strayed away enabling the patient to stray out and jumped to death. That was an actual case of *Res Ipsa Loquito*. In an action brought against the hospital, and the Hospital Board of Management the court found for the husband as it was a typical case of *Res Ipsa Loquitor.*

Other reported cases of *Res Ipsa Loquitor*, are; the case of *Mahonne vs. Osborne*[252] where an abdominal operation and some swabs were left in the patient. Others include- *Mrs. Rhoda Fadipe vs. UITH*[253] where some gauze was left in the abdomen of the patient and *Fish vs. Kapur*[254], where a dental extraction resulted to a fracture of the jaw. This maxim also was applied in *Cassidy vs. Ministry of Health*[255], where the plaintiff went to heal two stiff fingers but

[251] (1961) NWLR 173
[252] (1939) 2 K.B. 14
[253] Suit No.KWS/2/2001
[254]
[255] (1951) 2 K.B. 343

came out with four stiff fingers. This confirms the fact that it is only the plaintiff that will confirm the injury done to him/her except in the cases of *Res Ipsa Loquitor*.

5.4.0. CAUSATION – THE BUT FOR TEST

The proof – that the breach caused a particular damage is absolute and the burden of doing it lies with the plaintiff. In the case of *Ojo vs. Gharoro and UBTH*[256] , where the appellant had a surgical operation for the removal of a growth in her fallopian tube, because she had been unable to get pregnant. It was ascertained medically that the removal of the growth might make it possible for her to get pregnant. The surgical procedure was done by the 1st respondent and assisted by the nurse and the 3rd respondent. The appellant's alleged that in the course of the operation, the surgeon left a broken needle in her womb, resulting in very severe pain for which she claimed damages in this action. Tobi, J.S.C. dismissed the appeal and made important pronouncements saying that the only witness who gave evidence for the appellant is the appellant herself. She did not call any expert witness for her evidence and so her evidence struggled for the place with the expert evidence of 3 witnesses for the respondents.

Causation often raises difficult legal problems but the courts adopt a broad common sense approach in resolving them. The case of *Barnet vs. Chelsea and Kensington Hospital Management Committee*[257] is illustrative here. This is a case where a plaintiff's husband after drinking tea experienced vomiting for three hours, together with two other men who drank the tea with him. He was rushed to the hospital that night to the casualty department of the defendant hospital, where a nurse contacted the house officer on duty by telephone, telling him of the symptoms. The doctor himself was as well, tired, and sent a message back through the nurse, that

[256] Ibid
[257] (1968) 1 ALL ER 1068

they should go home and contact their own doctors in the morning. But some hours later, the plaintiff's husband died of arsenic poisoning and the coroner's verdict was one of murder by a person(s) unknown. In an action for negligence, the doctor was found guilty of negligence for a breach of duty of care, but this breach could not be said to be the cause of the death, because even if the doctor had seen him, he would still have been dead. It could therefore not be said that but–for– the doctors negligence, the deceased would have lived.

5.5.0. **REMOTENESS OF DAMAGE**

Although, the act of the defendant may have caused the harm complained of, nevertheless, the law does not hold a person responsible for all the direct consequences of that person's act. The person is liable only if such consequences as a reasonable man would foresee as the natural and probable consequences which are not foreseeable, are regarded by law as too remote. Damages are entirely compensatory and in no sense punitive and still less vindictive. But if damages are capable of being assessed, however, difficult it may be, the court will not shirk from attempting this. It was the decision of Olagunju J. (as he then was) in the reported case of *Rev. Joseph Alli vs. U.I.T.H.*[258] where he said that the description of the benefit that is due to the members of the deceased's immediate family as general damages appears to be analytical in exact.

This is because unlike some general damages that follow an ordinary breach of contractual or civil right which the law presumes are more often than not incapable of analytical verification. Damages under the Fatal Accidents Law are based on data which a combination of the earning capacity of the deceased and the loss of the individual dependant, suffers from the abrupt termination of the earning capacity of the bread winner proportionate to the benefit he or she

[258] (1992) Suit No. Kws/94/91

derived from the deceased income. In one, the assessment is purely arbitrary, in the other hand it is based on data which are ascertainable from defined sources that are products of an established relationship which has been involuntarily severed.

Another Nigerian case where the issues of causation and remoteness of damages arose is the case of *Mange vs. Drurie*[259] where the plaintiff, riding his bicycle along Jos Balewa Road when he was knocked down and suffered severe injury to his leg as a result of the negligent driver of a lorry. He was immediately taken to the hospital by the defendant – but later before his treatment was completed and against a medical advice, he discharged himself and did not return to the hospital until after two days. During the two days the leg became infected and was scheduled to be amputated. The plaintiffs claim for damages for the loss of his leg was rejected by Bates S.P.J, (as he then was) on the grounds that compensation will only be awarded in respect of a class of damage which the defendant could reasonably be expected to have foreseen. Compensation will not generally be awarded in respect of injury sustained as a result of the act or default of the injured party or to the extent to which the injured party has failed to take reasonable steps to mitigate the injury. In the present case, it was not reasonably foreseeable that the plaintiff would contrary to medical advice, leave the hospital where the defendant had taken him, and at least two days without proper surgical care or attention, which resulted to an infection that necessitated the amputation of his leg. Apart from the question of unforeseeability the plaintiff, by not taking reasonable steps to mitigate the damage, brought upon himself – the amputation of his leg by his own ill-advised action.

5.6.0. ASSESSMENT OF DAMAGES

[259] (1970) NNLR page 62

Although, the plaintiff may succeed in proving negligence and that he has suffered injury or harm, he must show that the injury or harm, resulted from the wrongful act or omission complained of and failure to establish this connection between the negligence and the alleged damage will not entitle him to judgement.

Damages for a loss of a digit or a limb, for loss of an eye or sight or smell, or for a scar or disfigurement or from shortened expectation of life cannot be measured according to any fixed rules. The age, the circumstances, prospects and so on, of the plaintiff have to be considered and damages awarded on the evidence. The award would be disturbed unless matters have been taken into consideration which were irrelevant or a wrong measure of damages was applied. Unless the damages are so excessive or so small as to make it an opinion of the court of Appeal, otherwise an entire erroneous estimate of the damages of the plaintiff's entitlement fails. The case of ***Flint vs. Lovell***[260] is instructive here. The judge may proceed upon some wrong principle of law, as in the case of *Gold vs. Essex County Council*[261] where the Judge awarded an infant lower damages than he would have awarded to an adult, on grounds that the amount, through accumulation of interest, would have substantially increased by the time the child came of age and was entitled to receive it.

Another good illustration on how the Nigerian judges often assess general damages in personal injuries, is in the case of *Anumba vs. Shohet*[262] where Taylor C.J. said that turning now to the general damages, the settled principle to be applied is where injury is to be compensated by damages, the court should as nearly as possible get at the sum of money which would put the party (who has sustained or suffered injury) for which he is now to get compensation in the case

[260] (1935) I.K.B. 354
[261] (1942) 419,425
[262] (1965 2 ALL N.L.R. at page 186

at hand, he thinks the plaintiff here, must be from a compensation to his injury, and such as will be fair assessment in the opinion of the reasonable man. He said he ought to take into account the pain that the plaintiff suffered from the injury to his leg and the handicap which he now suffers in calculating the damages which, as far as money can do it, he should be paid for the loss he has suffered as the natural result of the wrong which has been done to him. In this respect, he said he has to consider the fact that the plaintiff suffered a fracture of the left femur, as a result of which he was hospitalized for nearly three months, during which period he suffered pain. He also said he has taken into consideration the fact that the plaintiff still suffers pain and that it is not advisable to drive his own car. The burden now rests with the plaintiff to procure the services of a professional driver. The plaintiff told him that he swims, play tennis and foot ball. He said he could no longer do these things for reason of the injury and shortening. He has referred him to several decided cases in which varying sums of money have been awarded in cases of injury to different classes of claimants.

Taylor C. J., (as he then was) upon proving the existence of legal damages, the court becomes saddled with the responsibility of computing the quantum of damages which the plaintiff is ordinarily entitled to. In this vein, he said that there are no hard and fast rules which determine the amount of damages awarded a plaintiff as compensation for surgical negligence, this depends on the facts and circumstances of each case. However, there are some factors which should be taken into consideration and these include the nature of the injury, effect of the injury on the injured (that is as to whether it causes permanent disability or otherwise), the age of the injured etc. It would suffice to say that special and general damages may be awarded, recourse being made, of course, to the precepts dictated by the peculiarity of each case and circumstance.

5.7.0 JUDICIAL ANALYSIS OF CIVIL LIABILITY

When health care providers are alleged to have failed to observe the legal principles and standards concerning the care of patients, it may result to civil litigation. The most common and potent basis of civil liabilities are as a result of professional negligence. Thus, where a health care provider administers treatment to a patient negligently and injury is caused to the patient, he may sue for negligence against the provider for the injury suffered. The rationale for liability for negligence of a health care provider is that, someone harmed by the actions of such a provider deserves to be compensated by the injuring party. Chapter two of this thesis has discussed what must be proved in negligence. That is, the existence of duty of care, breach of the duty and proof of damage. This part would not repeat the discussion in this aspect.

5.7.1 *The Traditional Rule of Bolam Test*

In medical litigation, the central question that arises is whether or not a doctor has attained the standard of care that is required by law. The standard expected is one of reasonable care. This needs to be judged by taking into account all the circumstances surrounding a particular situation, and by balancing the diversity inherent in medical practice against the interests of the patient. An essential component of an action in negligence against a doctor is proof that the doctor failed to provide the required standard of care under the circumstances. Traditionally, the standard of care in law has been determined according to the *Bolam* test. This is based on the principle that a doctor does not breach the legal standard of care, and is therefore not negligent, if the practice is supported by a responsible body of similar professionals.

The case of ***Bolam vs. Friern Hospital Management Committee***[263] is an English tort law case that lays down the typical rule for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals (e.g. doctors). Mr. Bolam was a voluntary

[263] [1957] 1 WLR 582

patient at Friern Hospital, a mental health institution run by the Friern Hospital Management Committee. He agreed to undergo electro-convulsive therapy (E.C.T.). He was not given any muscle relaxant, and his body was not restrained during the procedure. He reacted violently before the procedure was stopped, and he suffered some serious injuries, including fractures of the acetabula. He sued the Committee for compensation. He argued that the doctors were negligent for: (1) by not issuing relaxants; (2) by not restraining the patient and (3) by not warning him about the risks involved. McNair J, (as he then was) at the first instance, noted that expert witnesses had confirmed that many medical opinions were opposed to the use of relaxant drugs and that manual restraints could sometimes increase the risk of fracture. Moreover, it was the common practice of the profession not to warn patients of the risk of treatment (when it is small) (as at that time) unless they are asked. It was held that what was common practice in a particular profession was highly relevant to the standard of care required. He said further that a doctor is not guilty of negligence if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art. Putting it the other way round, a man is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view.

It follows that if a medical practice is supported by a responsible body of peers, then the *Bolam* test is satisfied and the practitioner has met the required standard of care in law. This test has been applied on numerous occasions in cases of medical litigation. The application of the *Bolam* principle means that where there are two conflicting views on acceptable medical practice, then, as a matter of law, the jury could not find the defendant medical practitioner negligent. A strong endorsement of this test was provided in the House of Lords by *Lord Scarman* (as he then was),

in the case of ***Maynard vs. West Midlands Health Authority.***[264] His Lordship stated that what he has to say is that a judge's preference for one body of distinguished professional opinion to another also professionally distinguished is not sufficient to establish negligence in a practitioner whose actions have received the seal of approval of those whose opinions, truthfully expressed and honestly held, were not preferred. He also said that in the realm of diagnosis and treatment negligence is not established by preferring one respectable body of professional opinion to another.[265]

The reason for his Lordship's view is that there are, and will always be, differences of opinion and practice within the medical profession. One answer exclusive of all others is seldom the solution to a problem that requires professional judgment. A court may prefer one body of medical opinion to another, but that does not amount to a conclusion of clinical negligence. In practical terms, the effect of the *Bolam* Test is that a finding of negligence is not made where the defendant doctor has acted in accordance with a responsible body of medical opinion. This means that with respect to whether there has been a breach of a duty of care, the issue is what

[264] [1985] 1 All ER 635

[265] Ibid. see also the following cases: *Barnett vs. Chelsea & Kensington Hospital* [1968] 1 All ER 1068. Three men attended at the emergency department but the casualty officer, who was himself unwell, did not see them, advising that they should go home and call their own doctors. One of the men died some hours later. The post mortem showed arsenical poisoning which was a rare cause of death. Even if the deceased had been examined and admitted for treatment, there was little or no chance that the only effective antidote would have been administered to him in time. Although the hospital had been negligent in failing to examine the men, there was no proof that the deceased's death was caused by that negligence. *Whitehouse v Jordan* [1981] 1 All ER 267: The claimant was a baby who suffered severe brain damage after a difficult birth. The defendant, a senior hospital registrar, was supervising delivery in a high-risk pregnancy. After the mother had been in labour for 22 hours, the defendant used forceps to assist the delivery. The Lords found that the doctor's standard of care did not fall below that of a reasonable doctor in the circumstances and so the baby was awarded no compensation. *Sidaway vs Bethlem Royal Hospital Governors* [1985] AC 871: The claimant suffered from pain in her neck, right shoulder, and arms. Her neurosurgeon took her consent for cervical cord decompression, but did not include in his explanation the fact that in less than 1% of the cases, the said decompression caused paraplegia. She developed paraplegia after the spinal operation. Rejecting her claim for damages, the court held that consent did not require an elaborate explanation of remote side effects. In dissent, Lord Scarman said that the Bolam principle should not apply to the issue of informed consent and that a doctor should have a duty to tell the patient of the inherent and material risk of the treatment proposed.

would a reasonable person have done in the circumstances, in response to the foreseeable risk? Where the issue is professional negligence, then the question is what the reasonable person in that profession would have done. In that case, the court cannot usually answer the question without reference to the testimony of experts, for the question of what the reasonable dentist (as in this case) does is not a matter that a court can determines by reference to general experience. Evidence of medical expert will therefore be important, but not determinative, of the issue before the Court. The Court will, however, be reluctant to find a doctor who complies with the accepted practice of the profession at that time, negligent.

5.7.2 ***Criticisms of the Bolam Test***

Describing the criticisms about Bolams principles

The main issue about Bolams principles is that it has paid much attention to what has been done whether good or bad instead of what should be done rightly. The Bolam test would not deny that an action is negligent as long as it is in conformity with the professional and responsible opinion of body of medical men. It does not want to know whether the action the medical man had taken is of a reasonable standard of care expected of a man of that class. But it is more concerned about its conformity with the Body of medical opinion. The principles of Bolam tend to say that what ought to be done should be changed to what is done regardless of the standard of what is done, whether the practitioner is negligent or not, weighing all the circumstances surrounding the case.

The principles have made the medical practitioners to carve out for themselves the standard of care they would adopt whether it is in the positive or in the negative. One wonders whether this should be the case since in other professions it is the court that determines what standard of care that professions should adopt. The medical profession has been the only profession that has

adopted this standard of care. From the time immemorial, in *Stratton vs. Swanland*[266] and *Pollard vs. Dr. Cooper,*[267] with the emergence of Bolitho's decision, an awareness has been created on individual patients' rights on medical intervention about surgical or medical negligence. This is about ethical issues of any profession and fundamental rights of individual patients. People have consistently criticised the Bolam test and would rather prefer that the court should set the standard, of the profession instead of letting the profession set its own standard. *Lord Bridge* (as he then was) in the Sideway[268] case, where a case concerning the level of information disclosure to a patient, the justice said that a breach of duty of care is an issue that should be that primarily decided using the expertise of the professional Body of medical men. This is because he believed in the Bolam's principles.

5.7.3 *Sudden Shift from the Traditional Rule of Bolam Test*

Patrick Bolitho was an interesting case that helped to counter the harsh principles of Bolam. It was a case that dragged up to the house of Lords for the resolution. The case- Patrick was 2 years old when he had a brain damage which he sustained from cardiac arrest and respiratory failure. In his case- *Bolitho vs. City & Hackney Health Authority*[269], where he was admitted. His father Bolitho felt they were negligent on his treatment. The report was that the paediatric registrar did not see him to treat him. The female registrar had claimed that even if she had seen him, there wouldn't have been any difference and held that she was not negligent at all. Her response to this allegation was so negative and was even supported by so-called responsible Body of medical men.

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[266] (1374) (Ibid)
[267] (1765) Ibid
[268] Supra
[269] (1997) 4 ALL ER 771

But in the court, led by Lord Brown-Wilkinson (as he then was), had a different opinion from the Body of medical men. He said he had to be satisfied that the Body of medical men or professional Body of responsible, reasonable and respectable men's opinion that would be relied upon would be a considerable one. The Judge maintained that he has to take note of the necessary risks involved, weigh them against the benefits that should equally be involved. The court said it cannot pigheadedly accept the views just like that because it has come from the expert opinions of body of professional men of high repute. The court went further to say that before they could accept these views of medical men, it must have to put everything on the weighing scale to establish actually the truth of the matter.

This case from the highest court in the land, was able to counteract the effect of Bolam which stuck its judgments based on the Bolam's principles. It maintained that every case has to be assessed on its own merit and not to base it on the merit of professional Body of respectable, responsible Body of medical men. The court also said it has to have a wholistic approach to all the issues in contention, basing everything on the validity of each issue. A summary of discussion in Bolam and Bolitho cases regarding surgical and all medical negligence cases, the summary, is while in Bolam principle/test, the standard of care of the medical men was based on the principle of Bolam which is that, once the decision taken by the medical man is in support of the Body of professional, respectable and responsible medical men, who had held that opinion as right, there will be no problem. But not Bolitho's, the court has held the opinion that before an acceptance is made to the claim of the medical man, it has to weigh all the circumstances surrounding each case, the cost-effectiveness, the risks involved and the severity of the damages. The court would have a wholistic view on every issue concerned before it makes a decision on

the particular case. As it is now, people are satisfied that it would be no longer all Bolam's defensiveness but now would be Bolitho's justifiable case.

5.7.4 *A Brief Analysis of Bolam and Bolitho's Decisions*

In medical litigation, the test for the standard of care in law expected of doctors is based on the principle enunciated in *Bolam*. Put at its simplest, the test is that a medical practitioner does not fail to reach the standard of care if a responsible body of similar medical peers supports the action in question. The judgment in *Bolitho*, however, suggests a judicial move at the highest level to shift the balance from an excessive reliance on medical testimony supporting a defendant doctor, to a more enquiring approach to be taken by the court. In order to reach its own conclusion on the reasonableness of clinical conduct, the court will arbitrate on the standard in each case. This would operate within the framework of normative values held by society. Patient empowerment is a strong theme in the new health service. This is likely to act as a conjunctive force in shifting the traditional accepted practice approach to one whereby the standard of care is set by the court on the basis of expected practice. This would be determined by evaluating the reasonableness of competing options.

In practical terms, the court would scrutinise more intensely the basis on which defendant doctors proclaim the standard of care. There would be a requirement to justify this on a logical basis. The court would look for logical analysis, and the opinion expressed would have to be coherent, reasoned and evidence based.

The court would also apply a risk analysis approach by seeking justification of the medical decision taken against competing alternatives. The emergence of independent guidance on good practice would enable the court to utilise the *Bolitho* principle more proactively in setting the expected standard of care required of doctors, in cases of medical litigation. In other

words, it may no longer be sufficient for a practitioner's actions to be *Bolam*-defensible. The court would seek to determine whether such action is *Bolitho*-justifiable.

The rejection of *Bolam* does not however mean that there is no role for expert medical evidence in medical negligence hearings. The evidence is necessary to show what the ordinary practice in the field is so that the court can assess whether, as a matter of law, the defendant doctor has complied with the standard required of a reasonable person practising in the field. The fact that a defendant doctor has complied with ordinary practice will not determine the matter, for the court has the right and obligation to determine, in each case, what is the requisite standard of care. However, the court should be slow to intervene to substitute its judgement for the clinical expertise of a treating doctor when it can be shown that the decision in the particular case accorded with the ordinary practice.

The mere fact that there are two alternative treatments available will not establish negligence where the defendant has chosen or recommended one treatment over another. Also, a court will not, by mere preference of one view over another, find that the doctor was negligent for making a choice that the court, in retrospect, would not have chosen. There must be more than a mere preference before a court will find that a choice between competing views was wrong and negligent. Nonetheless, Bolitho has been hailed as ushering in the new Bolam.

5.8.0 NIGERIAN COURTS AND THE BOLAM TEST

Several persons die in Nigerian hospitals due to surgical/medical negligence. Yet, limited cases of these negligent cases are prosecuted and even fewer are reported. Some of the reasons for these are: long trial periods, corruption and a general mistrust of the judicial system. Therefore, many victims of surgical/medical negligence think twice before filing a case of surgical/medical negligence in the courts. The Harvard Medical Practice Study has found that only less than two

percent of injuries caused by surgical negligence leads to claim.[270] *However, there are few reported cases of surgical negligence and even as few as they are, the courts have not been able to utilise the opportunity to develop its own jurisprudence in this perspective. In fact, majority of cases on medical negligence have been decided by the Medical and Dental Practitioner Disciplinary Tribunal*[271] *and virtually all the decisions of the Tribunal were appealed to the Court of Appeal. However, the Court of Appeal and even the Supreme Court totally derailed from the substance of the case on grounds of technicalities. This, therefore, has not given the court the chance to set the rule once and for all. For instance,* in the Nigeria case of *Denloye vs. MDPDT,*[272] Denloye was charged with neglecting in a prolonged manner between 29th June 1966 and the 10th July 1966 a patient very seriously ill, extortion of the sum of 30 guineas from the patient's father as an inducement for him to treat the patient among other allegations. The Tribunal pronounced him guilty of infamous conduct in a professional respect and ordered removal of his name from the Medical Register. Also, in ***Alakija vs. Medical Disciplinary Committee,***[273] the committee ordered the removal of Alakija's name from the Register of Medical Practitioners for two years. Also, the case of ***Okezie vs.*** **Chairman MDPDT**[274] Dr Okezie was suspended from practice for six months for losing his patient **(**Mrs. Obiekwu) after a caesarian operation. In all these cases, the decisions of the Tribunal were set aside on grounds of technicality even though there were enough proof of surgical negligence of the surgeon of the surgeon/s involved. Therefore, it could be argued that from the foregoing cases that while the tribunal has been very justifiably firm when the cases that concerned breaches of the members,

[270] Harvard Medical Practice found that only less than 2% of injury caused by medical negligence leads to claim.
[271] Medical Law Report Part 2 – Judgment and Directions of Medical & Dental Practitioners Disciplinary Tribunal & other Medical Law cases – 200 -2006
[272](1968) 1 All NLR 306.
[273] (1959) FSC 38
[274] (2010) 26 WRN

the judges are rather very liberal in their judgment against surgeons and other doctors and have repeatedly quashed the decisions of the professional tribunals on technical grounds.

Notwithstanding, it is necessary to examine where the fault is coming from in Nigeria. To be able to establish the position in Nigeria, it is necessary to consider some cases. The first case to be examined is the case of *Igbokwe vs. University College Hospital Board of Management.*[275] This case was brought by the children and husband of the deceased. The deceased who was an in-patient in one of the maternity wards of the defendant Hospital Board was found missing from her bed. She had just given birth to a child following which her case was diagnosed as a suspected case of psychosis. She was given sedative treatment by the doctor on duty on the day. A staff nurse was asked to keep an eye on her. She disappeared from the hospital. The patient died as a result of injuries received after a fall from the 4th floor of the hospital. In his evidence, the House Governor of the UCH Ibadan said that if the staff nurse had complied with the doctor's instruction to stay with the patient the accident would not have occurred. For the plaintiff, it was submitted that the circumstance pointed to the failure of the defendant to protect the plaintiff. The Court found for the plaintiff and held that the hospital was negligent. Though this is a case of surgical negligence, the Court in this case was not able to set the parameters for determining when surgical negligence would arise as in the Bolam decision. This is also a clear case of vicarious liability. However, it is an authority as to when an employer would be vicariously liable for the act of his employee in a medical practice.

In another case of *Miss Felicia Osagiede Ojo vs Dr. Gharoro and 2 ors and UBTH,*[276] the appellant had a surgical operation for the removal of a fibroid growth in her fallopian tube. It was medically ascertained that the removal of the growth might make it possible for her to have a

[275] [1961] WRNLR 173
[276] [2006] 3 NSCJ; [2006] 10 NWLR Pt. 987, 173

pregnancy. The surgical procedure was done by 1st respondent who was assisted by the 3rd respondent. It was done in a hospital owned by the 2nd respondent, where 1st and 3rd respondents worked as the staff of the hospital. The matter that was brought and sworn by the plaintiff in the statement of claim in the trial court was that during the process of the operation, the 1st and 3rd respondents negligently left in her womb broken needles as a result of which she experienced great pains. She issued her writ of summons claiming against the respondents as the defendants, special and general damages totaling two million naira for negligence in the manner the surgical procedure was carried out.

At the trial, the 1st respondent gave evidence under cross-examination that the sterile needle left in the anterior wall of the plaintiff's abdomen does not constitute an infection. He also said that a surgical needle is not a strong tool and that it breaks or snaps easily. However, the only witness that gave evidence for the appellant was the appellant herself. She did not call any expert witness to give evidence; whereas, three witnesses were called by the defendants. That is, two medical doctors and a radiologist. All the courts, dismissed the patient's claim that is the High Court, the Court of Appeal and the Supreme Court holding that defendants were liable. The Appeal Court held that the defendants were not liable. The court held that in an action for negligence against professional person in connection with his calling, the question for consideration is whether on a balance of probabilities, it has been established that the defendant failed to exercise the care required of a man possessing and professing special skill in a situation that requires such special skill and that if there is an added burden, the person alleging negligence must do so.

At the Supreme Court, His Lordship, Justice Niki Tobi quoting Lord Denning with approval said that 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 so. He said that he must not therefore, find him negligent simply because something happens to go wrong. That he should only find him guilty of negligence when he falls short of the standard of a reasonably skilful medical man. The Judge went further to say that he would have been prepared to grant the plaintiff's claim for the estimated cost of the surgery believing 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.

A careful analysis of the case of *Miss Felicia Osagiede Ojo vs. Dr. Gharoro*[277] *and 2 others* shows that the Supreme Court is in full agreement with the Bolam Test. There is no doubt that a judge has little knowledge in medicine and as such he has to rely in most cases on expert opinions. However, both this case and the Bolam Test seem to rely heavily on evidence of an expert to be a conclusive proof that a surgeon or any medical practitioner is not negligent once he has been defended to have complied with reasonable standard which the court itself has no knowledge of. In this particular case, the defendants admitted that the broken needle was left in the plaintiff's abdomen 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. More so, there was incontrovertible evidence that it might be injurious. However, the defendant was not found liable simply because he has not fallen short of standard required of him. The consequence of this is that to succeed, the plaintiff must be versatile in medicine as to be able to controvert expert opinion. This means that the plaintiff must be as intelligent in surgery as the surgeon himself. The ubiquitous application of the rule of compliance with the standard of care in every issue surrounding medical litigation

[277] Ibid

should be perceived as an undue reliance on medical testimony and an unsatisfactory focus on the interests of the patient. The mere invocation of compliance with the required standard could be enough to defeat claims sufficiently contestable to reach the courts as illustrated in this case. This means that compliance with a recognised standard of care is conclusive in terms of escaping liability for medical negligence in Nigeria.

5.9.0 CRIMINAL LIABILITY OF A SURGEON IN NIGERIA

A person who is unskillful might choose to act as a medical doctor or a surgeon.[278] Such individual cannot vindicate his act by arguing that he did his best, if his best fell below the necessary standard of care. For example, if a bricklayer holds himself out as a surgeon and does an operation on another person, he will be required to show the ordinary competence normally possessed by qualified surgeon. He will be guilty of the result of falling short of that standard. This is because the law obliges him to hold the required skill and to use it. He will, in any case, be guilty of an offence involving negligence only if his conduct is negligent. It is the same in the case of a nursing sister, who runs a maternity home, parades as a surgeon, and performs a caesarean section, who consequently passes away by bleeding to death. Apparently, she does not possess the skillfulness of a competent surgeon. Therefore, she acted in an incompetent manner in reckless disregard for the life and safety of the woman and as such she will be held liable of the outcomes of her act. The activities of quacks, in the area of healthcare, have taken a toll on the lives of many Nigerians, especially the women folk. The courts, therefore, seem to punish them seriously for their negligent acts in order to discourage the practice of quackery. The case of *Celestine Yolofun vs. Nigerian Criminal Ivestigation Group Lagos State*[279] is illustrative here.

[278] Such an individual is known as a quack. In Nigeria, quacks abound
[279] Ibid

Negligence will attract criminal liability where the act amounts to an infraction of a penal statute which is prescribed as the mental element or state of the mind required for the commission of the offence. In chapter four of this thesis, the circumstances under which negligence may amount to a criminal act has been discussed and as such this aspect will not repeat the discussion. However, it needs be reiterated that culpability for medical negligence may be for the offences of murder, manslaughter or causing bodily injuries depending on the nature of the case. For instance, in the case of *Attah vs. State*,[280] the accused, a Health Centre Superintendent, had been parading himself as a qualified medical practitioner. On 27 January 1985, a friend accompanied one woman, Yetunde Sunday, to his house to procure an abortion (which is contrary to the provisions of this professional standard of practice). The accused carried out the operation in his residence. When the friend later came back to carry the woman back to her house, she was found lying motionless on the floor inside the house of the accused. On being informed about her condition, the accused assured the friend that it was due to the drug administrated on her, and that she will be okay later. He afterwards volunteered to assist the friend to carry the patient to her house in his car. The patient died and the accused was arraigned before the Ogun State High Court for murder and later was convicted and sentenced to death by hanging. The accused appealed the judgment at the Court of Appeal; the Court of Appeal affirmed the sentence and dismissed his appeal. In the case of ***State vs. Okechukwu,***[281] where a quack was sentenced to nine years imprisonment for manslaughter, the court noted in this case that he would stress that the incidence of medical quackery has been a cankerworm which must be stamped out if lives of innocent citizens must be protected from sudden and unnatural death. It is extremely dangerous for an ignorant mountebank like the accused to dabble in medical

[280] [1993] 4NWLR Pt. 268, 403-407
[281] (1965) E.N.L.R 91

science for which he is least qualified. This type of offence is very common nowadays and a deterrent sentence is called for in this case.

In a similar decision in the case of ***R vs. Richard Ozegbe***,[282] the accused was not a trained medical doctor but posed as one. A woman was brought to him one day with a swelling at the back of her armpit. The accused went ahead to incise the lump surgically and complications arose which led to the death of the woman. The Judge, Daddy Onyeame J. (as he then was) convicted the accused and while passing his judgment, made the following remark that A person who without education and being ignorant of the schedule of medicine and surgery, took upon himself to administer violent and dangerous treatment was guilty of the grossiest negligence and reckless disregard of the safety of the person whom he performed the operation.

A careful analysis of the above cases shows that criminal liability of a medical doctor or a surgeon can be seen from two perspectives. One is that of unskilled person and the second is that of a skilled surgeon or medical doctor. In the case of an unskilled person who continues to parade him/herself as skilled would be found criminally liable and could not rely on the defence that he has complied with a recognised standard of care and procedure. This is because his unskillfulness makes him incompetent to carry out any operation or prescribes a treatment and as such he would be seen to have shown no regard for the life of the affected victim. The other aspect is the skilled surgeon or a medical doctor. In this situation, the burden of proof lies greatly on the prosecution to establish negligence. This means that where a surgeon has negligently caused the death of a patient, as was seen in the case of *Surgeon Captain C.T Olowu*[283] such a surgeon may, upon conviction be sentenced to death or life imprisonment for manslaughter as the case may be. This is to say that every health professional must use reasonable care to treat

[282] [1955-1958]UNLR 152
[283] Supra

his/her patient and if the care expected of his caliber and skill did not meet the standard of care required, it would be regarded as being negligent in performance of his/her duties. He would be prepared to answer the full wrath of the law. Therefore, the prosecution might require expert evidence to prove his case and rebut that of the accused.

There has not been any specific law laid down by the Nigerian Court on the doctrine of negligence somewhat it may elect to agree with the opinion of the accused or not. On this basis, though, there is a role for expert surgical/medical evidence in surgical negligence hearings; it is suggested that such evidence should not be regarded as a conclusive proof of no liability. The evidence is needed to show what is the general practice within the field is so that the court can evaluate whether, as a matter of law, the accused doctor has observed the standard required of a reasonable person practising in the field. Therefore, the court should scrutinise more deeply the basis on which accused surgeons/doctors assert the standard of care. There should be a prerequisite to validate this on a logical basis. This means that the court should search for logical reasoning and the belief stated would have to be rational, coherent and evidence based.

5.10.0 CONCLUSION

From the foregoing, a gross mistake which may result in serious penalty from the surgeon runs contrary to the law. What the courts will consider is to determine whether surgeon's liability is the test of a reasonably competent surgeon. Thus, if the surgeon's conduct goes beyond what is expected of the skill of a reasonably competent surgeon, he will be liable. What is expected of a surgeon who manifests as possessing special skill and diligence is to use such diligence and care in the treatment of his patients because failure to use due diligence and skill earns him a legal action. However, so much wide discretion is given to the medical profession to determine the reasonable test. This is because once evidence is given that reasonable care has been exercised,

then no surgical negligence is established since the court itself lacks the scientific requisite to be able to ascertain it. This approach has indeed weakened access to justice to the victims of surgical/medical negligence. There is no doubt that the Nigerian state intends to set up a better state. As such, the state should not be looking the other way while the victims of medical mishaps are suffering and labouring under economic strangulation, ignorance, delay and technicality of court processes that deny them access to justice. This is more so with the widespread surgical negligence prevailing in Nigerian hospitals. There is the need for the court to jettison technicality and examine each case on its own merit in order to enhance access to justice against an erring surgeon/medical practitioner.

CHAPTER SIX

DATA ANALYSIS ON THE ASSESSMENT OF THE PERFORMANCE OF SURGEONS TO SURGICAL PATIENTS

6.0.0 INTRODUCTION

The issue that will be examined in this chapter has to do with the assessment of the performance of surgeons to surgical patients. This chapter is devoted to the analysis of the performance of surgeons in the pursuit of its mandate to exercise reasonable care to surgical patients in the theatre, wards and in the surgical clinics. The analysis done in this chapter is a product of data and information collected through questionnaires administered on the respondents.

6.1.0: STUDY AREAS

The study was carried out on surgeons, surgical patients and the surgical nurses. This was equally drawn from four hospitals, namely: University College Hospital (UCH) Ibadan, University of Ilorin Teaching Hospital (UITH), Ilorin, the National Hospital Abuja and Abia State Teaching Hospital, Aba. The choice of the hospitals is as follows:

The researcher is aware of the fact that better equipped hospitals like Lagos University Teaching Hospital, Lagos and Ahmadu Bello University Teaching Hospital, Zaria, which are within the zones the study was carried out on the hospitals chosen i.e. the North Central and South Western zones. The choice of these hospitals for the Researcher's study is because of the proximity of these hospitals that made the researcher to choose them.

The justification for the choice and the administration of the questionnaires to the chosen areas is due to some factors. The first is high personnel of professional surgeons as larger percentage of surgeries are being carried out in these hospitals on daily basis. The second justification is due to

the quality of equipment and instruments these hospitals have since these hospitals are being funded by the government.

6.2.0: POPULATION AND SAMPLE SIZE

The population of the study include the surgeons, surgical patients and surgical nurses in the hospitals selected out of the population. Out of the population, 870 questionnaires were administered. 800 were returned and out of which 580 were found usable.

There is an assumption that the larger the sample the better it will be. Because it will be a true representation of the population in the study. The sample was drawn from three geo-political zones and the Federal Capital Tertiary in Nigeria as earlier mentioned. Federal Capital Tertiary (FCT) is unique because it is a true reflection of the spread that the researcher requires.

Table 0 The usable questionnaires for the purpose of analysis.

S/N		Geo-Political Zones	Sample Sizes
1	Abia[284]	South Eastern Zone	134
2	Ibadan[285]	South Western Zone	134
3	Ilorin[286]	North Central Zone	230

[284] **Aba** is a city in the southeast of Nigeria and the commercial centre of Abia State. Upon the creation of Abia State in 1991, Aba was divided into two local government areas namely: Aba south and Aba north. Aba south is the main city center and the heart-beat of Abia State. Aba is a major urban settlement and commercial center is a region that is surrounded by small villages. It has a total population of 931,900 (2006 census). The University of Abia State Teaching Hospital is located at the heart land of Abaen.m.wikipedia.org=Reference.www.britanica.com

[285] **Ibadan** is the second largest city became the British Protectorate in 1893. University of Ibadan used as a college of the University of London and was later converted to an autonomous college in 1962. It has the distinction of being a premier educational institute in West Africa. It is the capital of Oyo state South West of Nigeria. It used to be the largest city in West Africa. The University College Hospital and University of Ibadan are located at the heart land of the city of Ibadan. The population is 3.8m as at (2006 census). (Info content.pg school.11.edu.ng) the post graduate school information content portal www.britanica.com

[286] **Ilorin** is the capital of Kwara State. The state has a population of 2,591,555 (2005 estimate). The capital city of Ilorin is situated at 306km in land from the coaster city of Lagos and 500km from federal Capital territory. The major towns are Offa, Jebba located at the Niger River, Omuaran, Pateji amongst others. The University of Ilorin Teaching Hospital is located at northern side of Ilorin. The Legal profession is very strong in Ilorin. The first lawyer to take the rank of the Senior Advocate of Nigeria (SAN) in the whole of the Northern Region is from Ilorin, his name is Alhaji A.G.F. Abdulrasak (SAN) he has at least two lawyer in his family. Justice Mustpha Akanbi retired, a renowned judicial court of Appeal president who was once the head of the independent corrupt practices commission (ICPC) he is also from Ilorin. He son is also a professor of Law in University of Ilorin. We also have the Belgore family where Justice Alfa Belgore who four of his sons as lawyers. Ilorin has produced so many senior Advocate of Nigeria. Presently it has so many senior advocate of Nigeria. www.britanical.com

4	Abuja[287]	Federal Capital Territory	82
	Total		580

However, the study population for this research involved surgeons, surgical patients and the surgical nurses at the various hospitals selected for this research. Therefore, a total number of 870 respondents were questioned in this study for quantitative data gathering. The choice of 870 respondents in this study has therefore enabled the researcher to cover the different categories/strata in the study.

6.3.0 SAMPLING TECHNIQUES

The researcher adopted stratified random sampling to cover the different strata in the study. Having identified the different strata, random sampling was used to distribute the questionnaires. In the context of this study, sampling involved recruiting a specific group of people who possess characteristics relevant to the research questions. These are people who, by virtue of their roles, are capable of contributing to assessing the performance of surgeons in the discharge of their duties. On this note, both purposive and snowball techniques were used in this study. The purposive technique enabled the researcher to reach out to those that are to be included in this research such as surgeons, surgical patients and surgical nurses. The choice of this technique is due to the area of interest of the present study. The researcher adopted stratified random sampling method to cover the different strata in the study. Having identified the different strata, random sampling was used to distribute questionnaires.

Purposive sampling

[287] **Abuja** this is the federal Capital of Nigeria. It has an approximated population of 1,400,000 as well as a surface area of 800km. It is the head quarter of the economic community of West African State (ECOWAS) and the regional headquarters of OPEC it is a big city where more than forty Embassies and fourteen consulates are situated. The national Hospital Abuja is located at the heart land of Abuja. It is one of the fastest growing cities in the world of today. www.britanica.com

Purposive sampling (also known as judgment, selective or subjective sampling) is a sampling technique which involves selecting a sample by judgement of researcher rather than using mathematical probability for selecting the sample. It is a non-random sampling method and it occurs when the designing of the sampling scheme in selecting the sample is not based on probability phenomenon but purely on the subjective judgment of the researcher. In purposive sampling researcher targets a group of people among population under consideration based on research purpose.

Example:

In a study of barriers to adequate prenatal care, researchers sought feedback from homeless women, women with substance abuse problems, partners of these women, and members of communities known to have inadequate prenatal care.

Snowball sampling

Snowball Sampling is a non-random sampling technique wherein the initial informants are approached who through their social network nominate or refer the participants that meet the eligibility criteria of the research under study. Thus, this method is also known as the referral sampling method or chain sampling method. For example, the group of people suffering from AIDS is limited and often reluctant to disclose their disease. And in such case, if the interviewer wants to know how the life of these people have changed due to AIDS, he might approach those acquaintances who can refer those individuals who will potentially contribute to the study.

6.4.0: RESEARCH INSTRUMENTS

This refers to the mechanism used in collecting primary data or information from the field. The study made use of a survey method for its data collection. Thus, questionnaires were administered to all the respondents at various levels. The administration of the questionnaires

provided a solid means of collecting information and it was also an effective means of reaching a large number of people within a considerable short period of time. Therefore, three structured questionnaires were drawn up to elicit responses from the respondents for the study. Questionnaire 1 was drawn up for surgeons, Questionnaire 2 was drawn up for surgical patients while Questionnaire 3 was meant for surgical nurses (theatre nurses and all those who are working in surgical wards and clinics) that have participated in surgery.

A self–administered questionnaire was employed for data collection at the various hospitals. The questionnaire items were designed primarily to obtain information from the surgeons, surgical patients and surgical nurses.

The respondents were required to appraise an agreement to the statements from the questions. A copy of the questionnaire is attached to the appendix.

6.5.0 METHOD OF DATA COLLECTION

The researcher personally visited the hospitals and distributed the questionnaires to the respondents based on the number assigned for each ward. This was after a pilot study was done in all the hospitals visited, and necessary corrections were made. The respondents were allowed time to fill in the questionnaires after which the researcher collected them back. This enhanced total collection. Any question that needed clarification was done by the researcher.

6.6.0 DATA ANALYSIS PROCEDURE

The responses of surgeons, surgical patients and surgical nurses perception from the questionnaires were analysed using Frequency Distribution Method.

6.7.0 PRESENTATION OF RESULTS AND ANALYSIS

Information was sourced, collected and collated so as to be represented in this study. Data analysis denotes the means by which the collected information is presented and construed in a meaningful way and in which details are given for observations.[288]

6.8.0 PERSON TO PERSON INTERVIEW

The purpose of the interview of the key players in the health industry and judges is to gather first hand information and also to cross-check opinions expressed in the questionnaires. The researcher was able to interview 20 surgeons, 30 surgical patients and 20 surgical nurses making a total of 70 interviewed randomly.

The interview questions were derived from the objectives of this study together with the existing literature. Person to person interview was conducted. Each interview lasted between 30 minutes and 45 minutes respectively, all, with a brief overview of the study. The interview questions were designed with the research questions.

6.9.0 DATA TABLES AND PRESENTATION

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The researcher's study was on 200 Surgeons, 200 Surgical Patients and 180 Surgical Nurses, equally drawn from four hospitals, namely, University College Hospital (UCH), Ibadan; University of Ilorin Teaching Hospital (UITH), Ilorin; National Hospital Abuja and Abia State University Teaching Hospital Aba.

RESULTS FOR SURGEONS

Table 1.1: Distribution of Surgeons by age

Age	Frequency	Percentage
20 – 29	22	11.0
30 – 39	90	45.0
40 – 49	50	25.0

[288]Soyombo, O. `Writing a Research Report' in Ahonsi, B. & Soyombo, O. (eds.) *Readings in Social research Methods and Applications*. Ibadan. Caltop Publications Limited, Ibadan, 1996

50 – 59	30	15.0
60 years and above	8	4.0
Total	200	100.0

Results from the table above shows that 22 (11.0%) of the Surgeons were between age 20-29 years; 90 (45.0%) were within age group 30-39 years; 50 (30.0%) in age group 40-49 years; 30 (15.0%) in the age group 50-59 years, while 8 (4.0%) of them were 60 years and above.
I appreciate the fact that an average medical doctor would not be less than 28 years to qualify as a surgeon, the age 20 on the table above should therefore, be discountenanced.

Table 1.2: Distribution of Surgeons on Educational Qualifications

Educational Qualification	Frequency	Percentage
MBBS, FWACS	120	60.0
MBBS, MSC, FWAC	50	25.0
MBBS, FACS, FWACS	30	15
Total	200	100.0

Result from the table above shows that 120 (60%) of surgeons have MBBS, FWACS Certificates, 50(25%) of Surgeons have MBBS, MSC, and FWACS Certificates, while 30 (15%) of surgeons have MBBS, FACS and FWACS Certificates. The table above confirmed that the surgeons are well qualified and are experts in their own field. This shows the competence and high skills in their performance in the treatment of surgical patients.

Table 1.3: Distribution of Surgeons by Religion

Religion	**Frequency**	**percentage**
Christians	150	75.0
Muslims	50	25.0
total	**200**	**100.0**

The above table revealed 150 i.e. (75%) of surgeons are practising Christians, while 50 (25%) of surgeons are practising Muslims. This shows that the surgeons are practising one religion or the other and they have the fear of God in them in treatment of their patients.

Table 1.4: Distribution of Surgeons by Ethnicity

Ethnicity	**Frequency**	**percentage**
Yoruba	120	60.0
Hausa	30	15.0
Igbo	50	25
Total	200	100.0

The results of the above table shows that 120 (60%) of surgeons are of Yoruba ethnic group, 30 (15%) of surgeons are of the Hausa group, while 50 (25%) of surgeons are of Igbo ethnic group. This confirms the spread the researcher wanted to get across the geo-political zones.

Table 1.5: Distribution of Surgeons by Gender

Gender	Frequency	Percentage
Male	122	61.0
Female	78	39.0
Total	200	100.0

From the table presented above, it is observed that 122 (61.0%) of the Surgeons were males while 78 (39.0%) were females.

Table 1.6: Distribution of Surgeons by number of years they have been Practising

Less than 10	Frequency	Percentage
10 – 19	108	54.0
20 – 29	50	25.0
30 and above	30	15.0
Total	200	100.0

The table shows that 108 (54.0%) of Surgeons had practised for less than 10 years; 50 had practised for between 10-29 years while 30 of them had practiced for 30 years and above. The above information shows that the surgeons have technical, professional expertise and ability to perform surgery competently.

Table 1.7: Distribution of Surgeons by whether they have performed surgery on Patients

Performed surgery on a patient	Frequency	Percentage
Yes	197	98.5
No	3	1.5
Total	200	100.0

It is observed from the table above that 197(98.5%) of the Surgeons reported that they had performed a surgery on a patient while 3 (1.5%) had never performed surgery on a patient.

Table 1.8: Distribution of Surgeons by the number of Surgeries they Perform in a Month

Number of Surgeries performed In a month	Frequency	Percentage
2 – 5	85	42.5
6 – 10	56	28.0
10 and above	59	29.5
Total	200	100.0

The table reveals that 85 (42.5%) performed between 2-5 surgeries in a month; 56 (28.0%) performed between 6-10 surgeries in a month while 59 of the Surgeons performed 10 or more surgeries in a month. This result would show that the surgeons were not excessively busy in the theatre, hence, the issue of surgical negligence arising from fatigue, acts of omission or commission would be expected to be minimal

Table 1.9: Distribution of Surgeons by the number of times a day the condition of surgical patients were checked and monitored.

Number of Days	Frequency	Percentage
Once	98	49.0
Twice	58	29.0
4 times	24	12.0
More than 4 times	20	10.0
Total	200	100.0

From the table above, 98 (49.0%) Surgeons monitored the surgical conditions of their patients once; 58 (29.0% monitored it twice; 24(12.0%) monitored the conditions 4 times while 20 (10.0) Surgeons monitored the surgical conditions of their patients more than 4 times. By this result, the surgical patients were properly checked by the surgeons.

Table 1.10: Distribution of Surgeons by whether all the surgeries performed were successful

Are all surgeries performed successful?	Frequency	Percentage
Yes	119	59.5
No	81	40.5
Total	200	100.0

From the results presented in the table above, 119 (59.5%) claimed that all surgeries performed by them were successful, while 81 (40.5%) reported that not all surgeries performed by them were successful. The result above shows that the 40% of surgeons who claimed that not all surgeries performed were successful, were honest. This gives room for improvement on their performance.

Table 1.11: Distribution of Surgeons by whether there are complications in any of the Surgeries performed

Complication in any surgery performed?	Frequency	Percentage
Yes	144	72.0
No	56	28.0
Total	200	100

From the results presented in the table, 144 (72.0%) Surgeons reported that there were complications in some of the surgeries performed by them, while 56 (28.5%) reported that there was no complication in any of the surgeries performed by them. This result shows a high level of professional competence and technical expertise by the surgeons. And there should be more rooms for improvement here also.

Table 1.12: Distribution of Surgeons by the nature of complications

Nature of Complications	Frequency	Percentage
Minor	147	73.5
Major	12	6.0
Minor and Major	41	20.5
Total	200	100.0

The above table shows that147 (73.5%) Surgeons reported that the nature of complications in the surgeries they performed were minor; 12 (6.0%) reported that they were major, while 41 (20.5%) reported that they had performed both minor and major surgeries. This result again indicates the professional competence of the surgeons in the theatre.

Table 1.13: Distribution of Surgeons by whether they know that they are under some legal obligations to their Patients

Knowing that you are under Obligation	Frequency	Percentage
Yes	195	97.5

No	5	2.5
Total	200	100.0

Results from the table reveals that 195 (97.5%) Surgeons reported that they had the knowledge that they were under legal obligations to their Patients, while 5(2.5%) reported that they had no knowledge of such legal obligations. The result indicates that the surgeons are well aware of the legal consequences of any surgical negligence. Therefore, the surgeons know very well that they are under legal obligations to their patients even though 5% said they are not aware of their legal obligations.

Table 1.14 : Distribution of Surgeons on how they would assess the Level of compliance by Surgeons under legal obligations of the surgical Patients.

Level of Compliance	Frequency	Percentage
Impressive	33	16.5
Good	146	73.0
Fair	16	8.0
Poor	5	2.5
Total	200	100.0

From the table above, 33 (16.5%) Surgeons reported that their assessment on the level of compliance by Surgeons with legal obligations was impressive; 146 (73.0%) reported that it was good; 16(8.0%) reported that their assessment on the compliance was fair while 5 (2.5%) reported that it was poor. With the above opinions of surgeons on the level of compliance it is expected that the issue of surgical negligence would be minimal and such awareness of legal obligations and compliance would help to safe guard the lives of surgical patients.

Table 1.15: Distribution of Surgeons by whether they are aware that Patients are entitled to some basic rights?

Aware that Patients are entitle to some basic rights	Frequency Percentage	Percentage
Yes	197	98.5
No	3	1.5
Total	200	100.0

From the results presented in the table above, it is observed that 197 (98.5%) of the Surgeons were aware that Patients were entitled to some basic rights while only 3(1.5%) had no awareness of the basic rights of the patients. What this result shows is that patients are treated decently and are accorded their basic rights as surgical patients. However, the 1.5% that is not aware has to be given some attention to.

Table 1.16 : Distribution of Surgeons on whether they are aware of the existence of surgical negligence

Any idea with issue of Medical Negligence	Frequency	Percentage
Yes	195	97.5
No	5	2.5
Total	200	100.0

The table presented above shows that 195 (97.5%) had an idea with the issue of the existence of surgical negligence, while 5(2.5%) claimed they had no idea of the existence of surgical negligence issue. The above result would indicate that such awareness would reduce the occurrence of surgical negligence because going by the popular saying that "to be forewarned is to be forearmed".

Table 1.17: Distribution of Surgeons by whether there has been Complaints against them, by the surgical patients.

	Frequency	Percentage
Yes	87	43.5
No	113	56.5
Total	200	100.0

From the above table 87(43.5%) respondent surgeons said Yes there had been complaints against them, while 113(56.5%) said there had never been complaints against them. The results of the above table would indicate that the existence of surgical negligence is fairly high. It will also indicate that the patients are aware of the need to exercise their rights if there is an infringement by the surgeons.

Table 1.18: Distribution of Surgeons by whether they have ever been prosecuted for surgical negligence

	Frequency	Percentage
Yes	17	8.5
No	183	91.5
Total	200	100.0

From the table, above17 (8.5%) Surgeons reported that they had been prosecuted for surgical negligence while 183(91.5%) reported that they had never been prosecuted. What could be interpreted from this result is either the surgical patients are frivolous or that authorities concerned with the investigation and prosecution seem to be lacking in their duty.

Table 1.19: Distribution of Surgeons on how they think a case of surgical negligence against a surgeon should be resolved

How should a case of negligence be resolved	Frequency	Percentage

By court	6	3.0
Private settlement	30	15.0
Disciplinary committee	164	82.0
Total	200	100.0

As observed from the results in the table, 6 (3.0%) of the Surgeons wanted the case of negligence against a Surgeon to be resolved by court; 30 (15.0%) wanted it settled privately, while 164 (82.0%) wanted the case to be referred to disciplinary committee. From the above results, it is obvious that the surgeons prefer their cases of surgical negligence to be resolved by professionals themselves despite the fact that empirical evidence had shown that the Disciplinary Committee/Tribunal of the association is more stringent than the law courts.

Table 1.20: Distribution of Surgeons by whether they are aware of any existing law on Medical ethics in Nigeria

Are you aware of any Medical ethics	Frequency	Percentage
Yes	188	94.0
No	12	6.0
Total	200	100.0

On whether or not the Surgeons are aware of any existing law on medical ethics in Nigeria, the table above shows that 188(94.0%) surgeons claimed that they were aware, while 12 (6.0%) claimed that they were not aware of any existing law. From the above results, it is expected that all surgeons would be guided by such medical ethics. The very fact that some surgeons are unaware of the existence of medical ethics in Nigeria needs to be looked into.

Table 1.21: Distribution of Surgeons by how effective the law of Medical ethics in Nigeria is

How effective is the law	Frequency	Percentage
Very effective	14	7.0
Effective	131	65.5
Fairly effective	50	25.0
Poor	5	2.5
Total	200	100.0

The table above presents the results on how effective the law on medical ethics is. As observed, 14 (7.0%) surgeons reported that the law was very effective; 131(65.5); reported it was effective; 50 (25.0%) reported that the law was fairly effective while 5(2.5%) reported that the law was poor. The implication of the above result is that there is a need for either improvement on the law

or ensuring stricter application of the laws. It calls also for more awareness of the laws among surgeons especially the newly qualified ones.

Table 1.22: Distribution of Surgeons by whether they are aware of the existence of MDPDC

Aware of Medical and Dental Practitioner's Disciplinary Committee	Frequency	Percentage
Yes	196	98.0
No	4	2.0
Total	200	100.0

From the table above, the number of Surgeons who were aware of the existence of MDPDC was 196 (98.0%), while the number of those who were not aware was 4 (2.0%). Even though the number that said No is too small, yet, it is a cause for concern.

Table 1.23: Distribution of Surgeons by how effective is the committee in the performance of her duties

How effective is the committee	Frequency	Percentage
Very effective	18	9.0
Effective	41	20.5
Fairly effective	137	68.5
Poor	4	2.0
Total	200	100.0

Results above show how effective is the MDPDC in the performance of her duties, 18(9.0%) reported very effective performance; 41 (20.5%) reported that the performance was effective; 137(68.5%) reported fairly effective performance of the duties by the committee while 4(2.0%) reported that the performance was poor. If one combines fairly effective with poor, then there is the need for the committee to become effective and efficient in the discharge of its duty so as to gain the confidence of the members.

Table 1.24: Distribution of Surgeons by whether they think that cases of negligence on Surgeons should be referred to Court

Cases of Negligence be referred to Court	Frequency	Percentage
Yes	30	15.0
No	170	85.0
Total	200	100.0

From the above table, presenting the results on whether or not the cases of negligence on Surgeons should be referred to the court at all, 30 (15.0%) of the Surgeons said the cases should be referred to the court while 170 (85.0%) said the cases should not be referred to the court. The

surgeons would want their professional body to resolve any issue arising from surgical negligence.

RESULTS FOR SURGICAL PATIENTS

Table 1a: Distribution of Patients by Age

Age	Frequency	Percentage
1 – 9	13	6.5
10 – 19	23	11.5
20 – 29	36	18.0
30 – 39	39	19.5
40 – 49	33	16.5
50 – 59	17	8.5
60 and above	39	19.5
Total	200	100.0

From the table above, 13 (6.5%) of the 200 patients covered in the study were between 1-9 years of age; 23(11.5%) were between 10-19 years; 36(18.0) were aged 20-29 years; 39 patients were between 30-39 years; 33(16.5%) were between 40-49 years; 17(8.55) were between 50-59 years while 39(19.5%) were aged 60 years and above.

Table 2a: Distribution of Surgical Patients by Religion

Religion	**Frequency**	**percentage**
Christians	70	35.0
Muslims	130	65.0
total	**200**	**100.0**

The above table revealed 70 i.e. (35.0%) of surgical patients are, practising Christians, while 130 (65.0%) of surgical patients are practising Muslims. This result above shows that all the surgical patients are of one religion or the other holding on to their beliefs in God for their healings.

Table 3a: Distribution of Surgical patients by Ethnicity

Ethnicity	**Frequency**	**percentage**
Yoruba	140	70.0
Hausa	20	10.0
Igbo	40	20
Total	200	100.0

The results of the above table shows that 140 (70.0%) of the surgical patients are of Yoruba ethnic group, 20 (10.0%) of surgical patients are of the Hausa ethnic group, while 40 (20.0%) of

the surgical patients are of Igbo ethnic group. The results above shows a good spread of the ethnic groups in Nigeria which the researcher intended to realise.

Table 4a: Distribution of Patients by Gender

Gender	Frequency	Percentage
Male	106	53.0
Female	94	47.0
Total	200	100.0

From the table it is observed that 106(53.0%) of the Patients were males while 94(47.0%) were females.

Table 5a: Distribution of Patients by Duration of Admission

Duration of Admission	Frequency	Percentage
1 day – 1 week	86	43.0
1 week – 1 month	64	32.0
More than 1 month	50	25.0
Total	200	100.0

From the table above, 86 (43.0%) patients were admitted in the hospital for 1day to 1week; 64 (32.0%) spent between 1 week and 1 month in the hospital while 50 (25.0%) were admitted for more than 1 month in the hospital.

Table 6a: Distribution of Patients by Section of Admission

Section of Admission	Frequency	Percentage
General Ward	172	86.0
Private Room	28	14.0
Total	200	100.0

The table above presents the section in which the patients were admitted. As observed, 172 (86.0%) were admitted in the general ward, while 28 (14.0%) were admitted in the private ward. The possible reasons could be financial or nature of the ailment.

Table 7a: Distribution of Patients on whether or not they have ever undergone surgery before this current one?

Undergone Surgery before	Frequency	Percentage
Yes	82	41.0
No	118	59.0
Total	200	100.0

From the results presented in the table, 82 (41.0%) patients reported that they had undergone surgery before, while 118(59.0%) reported that they had never undergone surgery before this current one. So, the experience of the majority of the patients about surgeons is limited.

Table 8a: Distribution of Patients by the number of times in a day their condition was monitored

Number of Days	Frequency	Percentage
Once	127	63.5
Twice	38	19.0
More than twice	35	17.5
Total	200	100.0

From the above table, 127(63%) of the Patients had their condition monitored once, 38(19%) had their condition monitored twice, while the condition of 35(15%) of the Patients were monitored more than twice. From the above result, it is observable that majority of the patients were checked regularity by the surgeons.

Table 9a: Distribution of Patients on whether the surgery was perfectly done without complication

Surgery Perfectly Done	Frequency	Percentage
Yes	150	75.0
No	50	25.0
Total	200	100.0

The results presented in the table above, shows that 150 (75.0%) patients revealed that the surgery was perfectly done, whereas 50(25.0%) revealed that it was not perfectly done. This is however expected as there is no perfection in performance in any job.

Table 10a: Distribution of Patients by nature of complication

Nature of Complication	Frequency	Percentage
Minor	177	88.5
Major	23	11.5
Total	200	100.0

The above table shows 177 (88.5%) revealed that the issue of complexity incurred by the patients was minor whereas 23(11.5%) revealed that the complication was major. The result above shows a good performance by the surgeons, though, the 11.5% has to be improved upon

Table 11a: Distribution of Patients on whether they were properly attended to.

Perfectly treated	Frequency	Percentage
Yes	147	73.5
No	53	26.5
Total	200	100.0

From the table, 147(73.5%) of the patients reported that they were treated perfectly, while 53(26.5%) reported that they were not perfectly treated. This result above shows a good performance by the surgeons and there should be more improvement on the 26.5% that complained that they were not treated perfectly well.

Table 12a: Distribution of Patients on whether they have complaints against the surgeon that performed their surgeries.

Complaints	Frequency	Percentage
Yes	57	28.5
No	143	71.5
Total	200	100.0

The table shows that 57(28.5%) of the patients reported that they had complaints against the surgeons that performed the surgery, while 143(71.5%) reported that they had no complaints against the surgeons. This is also expected as there is no perfection in any human activity. On the whole, the surgeons did their jobs satisfactorily. We still want them to close gaps by the 28.5% of those who had complaints, which is a bit high.

Table 13a: Distribution of Patients on whether they have idea with the issue of surgical negligence

Issue with medical negligence	Frequency	Percentage
Yes	71	35.5
No	129	64.5
Total	200	100.0

The table shows that 71(35.5%) of the patients reported that they had idea with the issue of surgical negligence, while 129 (64.5%) reported that they had no idea. This result accounts for why there are low reported cases of surgical negligence in Nigeria.

Table 14a: Distribution of Patients on how they would like negligence case against a surgeon to be decided

How negligence case should be decided	Frequency	Percentage
By Court	112	56.0
Conciliation	29	14.5
Private settlement	59	29.5
Total	200	100.0

On how the patients would like negligence case against surgeon to be decided, 112(56.0) patients opted for Court decision; 29(14.5%) opted for conciliation, while 59 (29.5%) preferred private

settlement. The results show the patients still have faith in the law courts even though when cases go to the law courts, patients lose out on grounds of technicalities most often.

Table 15a: Distribution of Patients by whether the case of negligence should be adjudicated by the court

Cases of negligence be adjudicated upon by court	Frequency	Percentage
Yes	127	63.5
No	73	36.5
Total	200	100.0

As observed, 127(63.5%) patients said they wanted cases of negligence to be adjudicated upon by the court, while 173(36.5%) said it should not be adjudicated upon by the court. The patients having faith in the judiciary would want the cases to be adjudicated by the court, given their responses in the study.

Table 16a: Distribution of Patients by how they think a surgeon should be punished for negligence

How a surgeon should be punished for negligence	Frequency	Percentage
Prosecution	113	56.5
Compensation	70	35.0
Pardon	17	8.5
Total	200	100.0

The table above shows that 13(56.5%) patients opted for prosecution as punishment for negligence; 70 (35.0%) of patients reported that surgeons should be made to pay compensation as punishment for negligence, while 17 (8.5%) wanted them to be pardoned. This still confirms that patients are of the view that they would obtain justice from the law courts if they report any case of medical negligence.

Table 17a: Distribution of Patients by whether they are aware of any existing law on medical practice

Aware of any law on Medical practice	Frequency	Percentage
Yes	70	35.0
No	130	65.0
Total	200	100.0

Based on the results from the table, 70(35.0%) patients were aware of the existing laws on medical practice while 130 (65.00%) claimed that they were not aware of any existing laws. The

result shows that the majority of the patients are ignorant of their rights regarding treatment. The implication of this is that cases of surgical negligence may happen without being reported.

Table 18a: Distribution of Patients on how effective the laws are

How effective the laws are	Frequency	Percentage
Very effective	23	11.5
Effective	60	30
Fairly effective	94	47.0
Poor	23	11.5
Total	200	100.0

23(11.5%) patients reported that the law on medical practice was very effective; 60 (30.0%) said that the law was effective; 94 (47.0%) claimed that the law was fairly effective, while 23 (11.5%) reported that the law on medical practice was poor. This result shows that majority of the surgical patients are aware of the laws of medical practice but they are handicaped by inadequate resources to process their rights.

Table 19a: Distribution of Patients by whether the interest of Patients are protected under the existing laws

Interest of Patients protected under existing laws	Frequency	Percentage
Yes	28	14.0
No	32	16.0
I don't know	140	70.0
Total	200	100.0

On whether the interests of patients are well protected under the existing law on medical practice, results from the table shows that 28(14.0%) patients reported that the interests were well protected; 32 (16.0%) reported that their interest were not well protected, while 140 (70.0%) claimed they didn't know. This again shows that majority of patients are totally unaware of their rights and privileges guiding medical services under the law.

Table 20a: Distribution of Patients by whether they are aware of the existence of MDPDC

Aware of medical and dental disciplinary committee	Frequency	Percentage
Yes	64	32.0
No	136	68.0
Total	200	100

From the table above, it is observed that 64 (32.0%) patients said yes to the question on whether they were aware of the existence of MDPDC, while 136 (68.0%) said they were not aware. This result explains why majority would prefer to go to court to report cases of surgical negligence instead of going to their professional body to report any case of surgical negligence.

Table 21a: Distribution of Patients by whether they know that they are entitled to some basic rights

Entitled to some Basic Rights	Frequency	Percentage
Yes	15	7.5
No	185	92.5
Total	200	100

Results from the table above reveal that 185 (92.5%) of the patients had no idea about being entitled to some basic rights, whereas 15 (7.5%) were fully aware of their entitlement to some basic rights. This result shows very low awareness among patients and by implication the society, of their fundamental basic rights. This result is not encouraging. On enquiry why cases of surgical negligence are not reported, they complained of length of legal process and lack of resources to process.

Table 22a: Distribution of Patients by whether there is need for a new law to penalize an erring surgeon

New law to Penalize an Erring Surgeon	Frequency	Percentage
Yes	115	57.5
No	21	10.5
I don't know	64	32.0
Total	200	100

From the results presented in the table, 115(57.5%) patients think that there should be a need for a new law to penalize an erring surgeon; 21 (10.5%) think that there is no need for a new law while 64 (32.0%) reported that they did not know. The results above suggest that there should be a new law because of their experiences in the recent judgments in the courts where the patients are not put into consideration... using technicalities to quash their cases in the court.

Table 23a: Distribution of Patients by how caring a surgeon is

How caring a surgeon is	Frequency	Percentage
Very caring	18	6.0
Caring	90	45.0
Fair	40	20.0
Uncaring	37	18.5
Very uncaring	15	7.5
Total	200	100.0

The results of the experiences of the patients regarding how caring the surgeons are reveal that 18(9.0%) of the patients reported that the surgeons were very caring; 90 (45.0%) reported that they were caring; 40 (20.0) reported that the surgeons were fairly caring; 37 (18.5%) reported that they were uncaring while 15 (7.5%) reported that the surgeons were very uncaring. This is not an unusual result given that there are individual opinions and judgments as to how surgeons perform their jobs. On the whole, the surgeons can be said to be professionally caring in the discharge of their duties. The 7.5% can be looked into and improved upon.

RESULTS FOR SURGICAL NURSES

A surgical nurse is one who possesses the requisite training and knowledge to function as a surgical nurse. She must have had the qualification as a general nurse, midwifery and diploma in theatre nursing certificate i.e. (R.N, RM, BSc, Nursing Diploma/certificate in surgical nursing and theatre technique nursing). The surgical nurse assists the surgeon in the theatre as "scrub nurse" and does other services in the theatre. She/he also works in the surgical wards, clinics and intensive care units, and any other area the services may be needed

Table 1.1b: Distribution of Surgical Nurses by Age

Age	Frequency	Percentage
20 – 29	50	27.78
30 -39	59	32.78
40 -49	46	25.56
50 -59	25	13.89
Total	180	100.0

The results shown in the table indicates that 50 (27.78%) were between ages 20-29 years; 59 (32.78%) were in the age bracket of 30-39 years; 46 (25.56%) fall within the age bracket of 40-49 years whereas 25 (13.89%) were between ages 50-59 years.

Table 1.2b: Distribution of Surgical Nurses on Educational Qualifications

Educational Qualification	Frequency	Percentage
RN, RM, Diploma Theatre Technique	100	55.56
RN,RM, BSc Nursing, Diploma Theatre technique	50	27.78
RN,RM, Surgical Nursing Diploma, theatre Technique	30	16.67
Total	180	100.0

Result from the table above shows that 100 (55.56%) of surgical nurses have RN, RM, and Diploma Theatre Technique Certificates, 50 (27.78%) of Surgical nurses have RN,RM, BSc nursing, and Diploma Theatre technique Certificates, while 30 (16.67%) of surgical Nurses have RN,RM, Surgical Nursing Diploma and Theatre Technique Certificates. The table above confirmed that the surgical nurses are well qualified and are experts in their own field too. This shows the competence and high skills in their performance in the treatment of surgical patients.

Table 1.3b: Distribution of Surgical Nurses by Religion

Religion	**Frequency**	**percentage**
Christians	40	22.22
Muslims	140	77.78
total	180	100.0

The above table revealed 140 i.e. (77.78%) of surgical nurses are practising Muslims, while 40 (22.22%) of surgical nurses are practising Christians. This shows that the surgical nurses are practising one religion or the other and they also have the fear of God in them in the treatment of their patients.

Table 1.4b: Distribution of Surgical Nurses by Ethnicity

Ethnicity	**Frequency**	**percentage**
Yoruba	100	55.56
Hausa	20	11.11
Igbo	60	33.33
Total	180	100.0

The results of the above table shows that 100 (55.56%) of surgical nurses are of Yoruba ethnic group, 20 (11.11%) of surgical nurses are of the Hausa group, while 60 (33.33%) of surgical nurses are of Igbo ethnic group. This also confirms the spread the researcher wanted to get across the geo-political zones of Nigeria and this pleases the researcher.

Table 1.5b: Distribution of surgical Nurses by Gender

Gender	Frequency	Percentage
Male	68	37.78
Female	112	62.22
Total	180	100.0

As observed from the table above, 68 (37.78%) of the Nurses who participated in the study were males, while 112 (62.22%) of them were females

Table 1.6b: Distribution of surgical Nurses by whether they are assigned to specific units, clinic or theatre

Assigned to specific unit, clinic or theatre	Frequency	Percentage
Yes	171	95.0
No	9	5.0
Total	180	100.0

From the results presented in the table above, 171 (95.5%) Nurses were assigned to specific units, clinic or theatre in their primary work place, while 9 (5.0%) was not specifically assigned. This means that surgical nurses are assigned to work in any surgical area of assignment.

Table 1.7b: Distribution of Surgical Nurses by Experience as Surgical Nurses

How long have you been a Surgical Nurse	Frequency	Percentage
2 – 5 years	68	37 .78
6 -10 years	52	28.89
10 and above years	60	33.33
Total	180	100.0

On how long they have been surgical nurses, 68 (37.78%) of them had been surgical nurses for 2-5 years; 56 (28.89 %) had been for 6-10 years, while 60 (33.33%) of them had been surgical nurses for 10 years or more. The result shows that all the surgical nurses were trained as surgical nurses to work in a specified area of surgery.

Table 1.8b: Distribution of Surgical Nurses by whether they have participated in surgery

Have you participated in surgery	Frequency	Percentage
Yes	174	96.67
No	6	3.33
Total	180	100.0

Results in the table above indicates that 174 (96.67%) had participated in surgery, while 6(3.33) claimed they had never participated in a surgery.

Table 1.9b: Distribution of Surgical Nurses by the number of surgeries In which they had participated

Number of surgery	Frequency	Percentage
Less than 5	48	26.67
5 – 10	46	25.56
More than 10	86	47.78
Total	180	100.0

The results in the table indicate that 48 (26.67%) nurses had participated in less than 5 surgeries; 46 (25.56%) had participated in between 5-10 surgeries, while 86 (47.78%) Nurses had participated in more than 10 surgeries. This result shows that majority of the surgical Nurses had participated in various aspects of surgeries.

Table 1.10b: Distribution of Surgical Nurses by stage of their participation in surgery

Stage of involvement	Frequency	Percentage
Pre – operative stage	50	27.78
Intra – operative stage	100	55.56
Post –operative stage	30	16.67
Total	180	100.0

The results in the table shows that 50 (27.78%) of the surgical nurses had participated in surgeries at pre-operative stage; 100(55.56%) had participated at intra-operative stage, while 30 (16.67%) had participated at the post-operative stage. This result shows that majority of the surgical nurses had participated at various stages of their assignment, and they have experience of all the stages of their operations.

Table 1.11b: Distribution of surgical Nurses by whether all the surgeries they participated in were successful

Are all surgeries successful	Frequency	Percentage
Yes	77	42.78
No	103	57.22
Total	180	100.0

From the results presented in the table above, it is observed that 77 (42.78%) of the Nurses reported that all the surgeries they participated in were successful, while 103 (57.22%) reported that not all were successful. From the above table, it shows that the number that was not successful was a bit high and this calls for more caution and competence of the surgeons.

Table 1.12b: Distribution of Surgical Nurses by whether there were Complications in some surgeries in which they participated in.

Complication in some surgeries	Frequency	percentage
Yes	125	69.44
No	55	30.56
total	180	100.0

The results from the table indicates that 125 (69.44%) experienced complications in some of the surgeries they participated, in while 55(30.56%) had no complication in any of the surgeries they participated in. This number of complications in the table above is quit high and corroborates the results in table (1.8b), this calls for more diligence, commitment and dedication on the part of surgeons.

Table 1.13b : Distribution of Surgical Nurses by Nature of Complications

Nature of Complication	Frequency	Percentage
Minor	101	56.11
Major	53	29.44
Both	26	14.44
Total	180	100.0

The results in the above table show that 101 (56.11%) of the surgeries they participated in was minor complications; 53 (29.44%) of the surgeries they participated in was major complications while 26 (14.44%) was both minor and major complications. The result on this table still confirms that the number of major complication was high and it calls for concern and increase in their effort to cater for their patients.

Table 1.14b : Distribution of Surgical Nurses by how Surgical patients are treated

How Surgical Patients are treated	Frequency	Percentage
Perfectly well	30	16.66
Very well	100	55.56
Good	43	23.89
Fair	7	3.89
Total	180	100.0

The results show that 30 (16.66%) of the Nurses reported that surgical patients were treated perfectly well; 100 (55.56%) reported that they were treated very well; 43 (23.89%) reported that they received

good treatment, while 7(3.89%) reported that they were treated fairly well. The result shows that the patients generally were treated well by the surgeons.

Table 1.15b: Distribution of Surgical Nurses on how to describe the attitude of most surgeons in the Theatre

Attitude of Surgeons	Frequency	Percentage
Very impressive	27	15.0
Impressive	86	47.78
Good	64	35.56
Unimpressive	3	1.67
Total	180	100.0

On the attitude of most surgeons in the theatre, the table shows that (15.0%) described their attitudes as very impressive; 86 (47.78%) described it as impressive; 64 (35%) described it as good, while 3 (1.67%) reported that their attitudes as unimpressive. The result shows that on the whole the surgeon's attitude was good given the responses of the nurses, this means there is a good team work in the theatre without a team work there will be no progress in theatre.

Table 1.16b: Distribution of Surgical Nurses on how the Nurses assess the level of commitment of surgeon to work

Level of commitment of surgeon to work	Frequency	Percentage
Very impressive	47	26.11
Impressive	61	33.89
Good	63	35.0
Unimpressive	9	5.0
Total	180	100.0

Results of the analysis as presented in the table indicate that 47(26.11%) of the Nurses assessed the level of commitment of most Surgeons to work as very impressive; 61 (33.89%) assessed it as impressive; 63 (35.0%) reported that their attitude to work was good, while 9(5.0%) reported it as unimpressive. Although nurses are not competent to assess the commitment of the surgeons to surgical patients, however, nurses can chip in, areas they find lacking and draw the attention of the surgeons to such areas.

Table 1.17b: Distribution of Surgical Nurses on whether the environment is good enough to ensure safety of Surgical Patients

Is the Environment Good enough	Frequency	Percentage
Yes	168	93.33

No	12	6.67
Total	180	100.0

On whether the environment is good enough to ensure safety of a surgical patient, 168 (93.33%) of the nurses reported that the environment was good enough, while 12 (6.67%) reported that the environment was not good enough. This result is very good because environment plays a major role in the recovery of surgical patients

Table 1.18b: Distribution of Surgical Nurses by whether they have any idea with the issue of Surgical Negligence

Having Idea with issue of Surgical Negligence	Frequency	Percentage
Yes	154	85.56
No	26	14.44
Total	180	100.0

The table indicates that 154 (85.56%) had idea with the issue of surgical negligence, while 26 (14.44%) had no idea with the issue. This issue calls for concern in respect of surgical nurses because they are all expected to have idea on the issue of surgical negligence. It also calls for more training and enlightenment for the nurses including other health care practitioners.

Table 1.19b: Distribution of Surgical Nurses on whether they are aware that Surgeons owe some legal duties to their Patients

Aware that surgeons owe some legal duties to Patients	Frequency	Percentage
Yes	167	92.78
No	13	7.22
Total	180	100.0

From the table above, 167 (92.78%) of the Nurses claimed that they were aware that surgeons owe some legal duties to their patients, while 13 (7.22%) claimed that they were not aware. This result is important since nurses are in position to advise the surgeons where there are some lapses regarding such duties.

Table 1.20b: Opinions of Surgical Nurses on Surgeons commitment to the work

How diligent the Surgeon are	Frequency	Percentage

Very impressive	14	7.78
Impressive	48	26.67
Good	110	61.11
Unimpressive	8	4.44
Total	180	100.0

On the diligence of the Surgeons in the performance of their duties, 14 (7.78%) of the Surgical Nurses reported that their performances were very impressive; 48 (26.67%) claimed that they were impressive; 110(61.11%) reported that their performances were good while 8(4.44%) Nurses reported that they were unimpressive. The result shows that majority of the surgical nurses appreciate the diligence of the surgeon in the performance of their duties though the minor percentage of (4.44%) should not be over-looked because they are dealing with human beings. The bad eggs in the profession should be identified and cautioned.

Table 1.21b: Distribution of Surgical Nurses by how they would prefer a Non-compliance against a Surgeon be dealt with

How should a non-compliance case be dealt with	Frequency	Percentage
Prosecution	35	19.44
Payment of compensation to the victim	60	33.33
Referral to Disciplinary Committee	85	47.22
Total	180	100.0

Results on the Surgical Nurses' preference on how a non-compliance case against a Surgeon should be dealt with are presented in the table above. As observed, 35 (19.44%) of the Nurses opted for prosecution; 60 (33.33%) preferred that erring surgeons should be made to pay compensation to the victims, while 85 (47.22%) preferred that they should be referred to the disciplinary committee. From the above result opinions of the nurses varied.

Table 1.22b: Distribution of Surgical Nurses by whether they are aware of Code of Conduct for Surgeons/Medicals Practitioners

Are your aware of Code of Conduct	Frequency	Percentage
Yes	163	90.56
No	17	9.44
Total	180	100.0

Results of the analysis also reveal that 163 (90.56%) of the Nurses were aware of Code of Conduct for surgeons, while 17 (9.44%) claimed that they were not aware.

Table 1.23b : Distribution of Surgical Nurses by how satisfied they are with the level of compliance with the Code of Conduct by Surgeons

Level of Compliance	Frequency	Percentage
Very satisfied	16	8.89
Moderately satisfied	123	68.33
A little satisfied	26	14.44
Dissatisfied	11	6.11
Very dissatisfied	4	2.22
total	180	100.0

On how satisfied the Nurses are on the level of compliance with the Code of Conduct by surgeons, 16 (8.89%) of them were very satisfied; 123 (68.33%) were moderately satisfied; 26 (14.44%) dissatisfied, while 4 (2.22%) were very dissatisfied. The result shows that surgeons are professionally doing their work and nurses acknowledge that.

Table 1.24b: Distribution of Surgical Nurses by how satisfied they are being Surgical Nurses

How satisfied are you being a surgical Nurse	Frequency	Percentage
Very satisfied	138	76.67
Moderately satisfied	25	13.89
A little satisfied	8	4.44
Dissatisfied	5	2.78
Very Dissatisfied	4	2.22
Total	180	100.0

From the results of the analysis presented in the table, 138 (76.67%) of the Nurses were very satisfied being a surgical Nurse; 25 (13.89%) were moderately satisfied; 8(4.44%) of them were a little satisfied; 5(2.78%) were dissatisfied while 4 (2.22%) of them were very dissatisfied. The result shows that 76.7% of the nurses were very satisfied from the result of the analysis, majority of the nurses are satisfied being surgical nurses.

This is important because without being satisfied as surgical nurses there could not be a high level of commitment and professional dexterity in the discharge of their duties in the surgical areas of their assignments.

6.10.0 DISCUSSION

This study was conducted on surgeons, surgical patients and surgical nurses in order to assess their perceptions on the performance of surgeons in the discharge of their duties. In all five hundred and eighty (580) respondents were surveyed comprising 200 surgeons, 200 surgical patients and 180 surgical nurses. The demographic characteristics shows that the male gender dominated the responses for both the surgeons and the patients while the female dominated the responses for surgical nurses.

From the findings of the study, 54% of surgeons have been practising for less than ten years (10 years) which is higher than the sum total of those that have been practising for 10-19, 20-29, and 30 and above. It is also discovered that 98.5% had at least performed surgeries on patients while 1.5% had not performed any. This has enabled the researcher in collating proper information necessary for the desired assessment. This shows that surgeons have enough technical and professional expertise and ability to perform surgery competently. For proper discussion of this study, the major issues for consideration came under the following three heading:-

(a) Opinions of surgeons as to their legal obligation and other related issues.

(b) Opinions of surgical patients on the performance of surgeons.

(c) Opinions of surgical nurses on the performance of surgeons

6.10.1 ***Opinions of Surgeons as to their legal obligation and other related issues***

The findings of the study show that the surgeons monitor their patients regularly in the discharge of their duties. The percentage that is of different opinion is insignificant even though there is no regulated standard of how many times a day a surgical patient can be monitored. This depends

actually on the condition of the patients, the circumstances and the type of surgery performed. If it is a major surgery like cardio-thoracic, neurosurgery, urology, vascular surgery, and so on, these are of high risk in nature. To prevent infections or any complications that may arise the surgeons may monitor their patients up to four times per day, if such a case is of a high-risk in nature, or else they can monitor once or twice per day.

Nursing care of these patients has to be up to date to monitor vital signs, fluid intake and output, and reactions from fluid intakes especially in cases of blood transfusion. Monitoring of the patients post-operatively is very fundamental. If the patient is not adequately monitored for the first twenty-four to thirty-six hours (24-36 hours) and the patient gets into crisis, the surgeon will bear the full outcome of the crisis. This is in line with the intendments of the American Best Practices and also in line with the World Medical Best Practices, California. However, the significant number on the responses that said their monitoring is insufficient will not be completely overlooked. Therefore, there is the need for those surgeons to improve on their monitoring especially post-operatively.

This further raised the questions as to whether the surgeons are aware that they are under legal obligations to their patients. The number that responded that they are aware is quite high, 97.5% as against the number in the negative, 2.5%. This is very encouraging. It becomes a guide in the performance of the legal obligation. However, the negative number should be paid attention to. This is because what we are talking about here is the life of a human being which is sacred and no one would want to lose a limb. This indeed buttresses the contention that surgeons must endeavour to improve their level of care, diligence and commitment in the care of their patients.

On the issue of knowledge of surgical negligence, 97.5% reported they had knowledge of the issue of surgical negligence, while, 2.5% had no knowledge of surgical negligence. The result indicates that such awareness would reduce the occurrence of surgical negligence because of the popular saying that to forewarn is to forearm. On the number of surgeries performed in a month, the study indicates that 42.5% performed surgeries 2-5 times in a month, 28% performed 6-9 surgeries in a month, while 29.5% performed more than 10 surgeries per month. This result shows that the surgeons were not excessively busy (except in cases of emergencies) so, the issue of surgical negligence arising from fatigue, acts of omission or commission would be expected to be minimal.

On whether there had been some complaints against the surgeons from the patients, 43.5% of surgeons said yes there had been complaints against them, while 56.5% said there have never been serious complaints against them. This result would indicate that the existence of surgical negligence is fairly high. It also indicates that the patients are aware of the need to exercise their rights if there is an infringement by the surgeon. See the complaints list at the appendix table.

On whether the surgeons are aware of the existence of medical ethics in Nigeria, the results show that 188 (94%) of respondent surgeons said they are aware of the existence of medical ethics, while 12 (6%) said they are not aware. From the results, it is expected that all surgeons include all doctors are guided by the dictates of Medical ethics guiding their profession. The very fact that some surgeons are unaware of the existence of medical ethics in Nigeria is very worrisome. This gives cause for concern, except perhaps they were just joking. This is absurd for somebody asking if they are aware of the existence of medical ethics. I presume it would be a joke else, it would be of concern to the public. I cannot understand why a surgeon

who has undergone all the medical training and sworn an oath cannot be conversant with medical ethics.

About the functionality of the medical ethics are in Nigeria, the result of the study shows that it is quit functional though opinions varied. While 7% of the surgeons responded that it is very effective, 26.5% said it is effective, 25% said it is fairly effective, while 2.5% claimed it is ineffective (poor). The importance of the above result is that there is a need for improvement on the laws or ensuring stricter application of the law. It calls also for more awareness to all the surgeons both the old and the new especially the newly qualified ones. It is on note that any medical doctor who is unaware of the medical ethics should not practice at all. This is the purport of the Oath they swear on their graduation day called (the Geneva). The details of the oaths have already been discussed in chapter four of this thesis; both the original and the current oath.

On whether there were complications in the surgeries they performed, the results show that 72% of the respondent surgeons said there were complication in some of the surgeries they performed while 28% said there were no complications. The percentage of the complication on this result is on the high side. This indicates that the surgeons should be more careful and use all diligence and skill to carry out their duties. The National Patient Safety Agency, UK, in their MOTTO supplemented this in Being Open. The Being Open guidance describes in some details a process and structural mindset for dealing with any potential adverse incidents. The 3rd highlight principle recommends that where harm had resulted from a patient's safety, an appropriately – worded manner of apology, should be given as soon as possible after the incident, both in writing and face to face. Any delay is likely to increase the sense of anger, frustration or upset of the

patient or relations who are taking care of the patient.[289] A survey of why patients and their relatives pursue negligence claims in Nigeria shows that lack of good communication plays an important role.[290]

This position was adopted in ***Medical and Dental Practitioner's Investigation Panel (MDPIP) vs. Dr. Emelumadu***[291], where a surgeon was accused of misdiagnosis when he diagnosed a leg ulcer (varicosities leg) (L), severe bilateral genuvalgus without evidence of taking the patients history and carrying out diagnostic tests. The issues raised in the complaint were based on the information received from the surgeon resident in America. (The son of the deceased demanded for the case file from Nigeria and he was given.) The complainant has also deposed to an affidavit that the surgeon did not show sympathy nor offered an apology at the demise of their dad. Commenting, the chairman of the Tribunal (MDPTD) said in some proceedings that an apology can be a mitigating factor and lack of apology can be an aggravating factor. The practice of never apologising is not in the public interest because it leads to litigation rather than reconciliation.

He said, every one, irrespective of his/her societal/ educational status wants to be assured that his or her doctor cares. An apology offered timely, sincerely and with good sense of remorse may be useful and beneficial for both parties.

Commenting further he said, practitioners should note that it is not in all cases that the Disciplinary Tribunal will find the respondent doctor liable, however, the moment a medical practitioner appears before the Disciplinary Tribunal of the council, it is no longer a win-win

[289] 10. Medical Law Report, part 21, Vol.1, part 2 March 2015
[290] Washington PM National Academic Press (2000) p.26, to erib human building a safer Health system Kohn J. Corrigan M, Donalson
[291] Charge No. MDPDT/26/2004

situation for the doctor even if the practitioner is eventually exonerated. The practitioner apart from the financial cost of defending the action, may end up being traumatized, psychologically battered, and may lose some form of credibility and professional reputation at the completion of the trial. The age of deference is past. Why not offer an apology?

On the nature of complications, the result shows that 73.5% of the surgeons said that the complications were minor, while only 6% said the complications were major. This result again indicated the professional competence of some of the surgeons in the theatre. On whether the surgeons know and are aware that patients are entitled to some basic rights; 98.5% of the respondent surgeons said they are aware that patients are entitled to some basic rights, while 1.5% of the surgeons said that they are unaware. This result is almost in the same line with some surgeons who are unaware of medical ethics. Without the patients, the surgeons will not be there so, for a medical practitioner to be unaware of the patient's basic rights calls for question. However, the large percentage of awareness is quite encouraging. This result shows that patients are treated decently and accorded their basic rights as surgical patients.

On the level of compliance to legal obligations the results here show that 16.5% of the respondents are of the opinion that their compliance is impressive, 73% said their compliance is good, 8% said it is fair, while 2.5% is of the opinion that compliance is poor. With this result on level of compliance by surgeons, it is expected that the issue of surgical negligence would be minimized. Such awareness of legal obligation and compliance would help to safeguard the lives of surgical patients.

Furthermore, on how effective the MDPDC is, 90% responded to be very effective, 20.5% to be effective, 68.5% to be fairly effective, while 2% respondents said it was very poor. The findings at least pointed to the fact that all together

98% of the surgeons are at least satisfied with the performance of the committee. This however is not to deny that from the responses of the surgeons, that the committee is efficient. Therefore, the results of the study in the thesis revealed that the surgeons are quite aware of their existing legal obligations and indeed exercising due diligence in the performance of their duties.

However, there may be very few bad eggs as the results have revealed, we call on the conscience of those ones to emulate the good deeds of the good surgeons. On the issue of the performance of the MDPDC, it is on record that they follow the issues of professional negligence of the medical practitioners committedly and sees it to its logical conclusion with sanctions to the erring professional medical practitioners. The Tribunal has actually been justifiably strict to the reported cases of ethical issues of surgical negligence in Nigeria and had done very creditably well. The problem is actually the judiciary who has from time immemorial taken a liberal approach to the ethical breaches and repeatedly quashed the decision of the Tribunal on technical grounds.

The patients had not been put into consideration except for very insignificant number of patient as was the case in ***DR DELE ABEGUNDE vs. University of Ilorin Teaching Hospital (U. I. T.H)***[292]***;*** where the negligence against a surgeon was established and the plaintiff was awarded a whooping sum of 5 million naira compensation. Alternatively, the case of *Miss*

[292] (2006) 10 NWLRSC/25

Felicia Ojo Osagiede Vs University of Benin Teaching Hospital (UBTH) and Dr. Gharoro, and Anor, the reverse is the case.[293]

6.10.2 Opinion of Surgical Patients on the performance of surgeons.

Of the 200 patients covered in this study, 6.5% was between 1-9 years of age, 11.5% was between 10-19 years, 18% was aged 20-29 years, 19.5% was aged 60 years and above. However, 33.0% of the patients were males while 47.0% were females. On the distribution of patients by the number of times in a day their condition was checked and monitored, 63% of the patients said their conditions were checked once, 19% had their condition checked twice, while 15% of the patients were checked more than twice per day. This finding is similar to that of the reactions of the surgeons because larger percentage of surgeons, 49% monitored their patient's condition once per day. The finding further justified the contention for improvement in the monitoring of the conditions of their patients. This is because in a more critical patient, monitoring once a day would not be adequate.

Though, the researcher knows that most critically-ill patients are either kept in the intensive care unit for 24 hours or more for critical monitoring while few critical ones in the wards are also specially monitored. Sometimes a house officer or resident is deployed to stay with the patients for 24 hours or more until the condition improves. On the distribution of patients by section of admission; the results show that more patients were admitted in the general wards- 86%, while only 14% was admitted in private wards. The possible reason given when enquired was that majority of those patients in the general wards have financial problems. That many of them were not able to pay the meagre deposits, and some of them were even being

[293] Suit No: FHC/IL/CS/20/2008, miss Felicia Osagiede Ojo Vs. Dr. Gharono and University of Benin Teaching Hospital Management Board & Dr S.A Ejide 2, where an issue of surgical negligence was established but the court could not her any damages.

helped by the nurses and doctors. The story of the poverty level of many patients is the same in all the hospital the researcher visited. In one of the hospitals visited, the researcher had to contribute to a purse of campaign being done for a patient who could not pay for her operation.

As to whether the patients had undergone surgery before this currents surgery the results show that 41% had undergone surgery before this currents one, while 59% had not undergone surgery before this current one. So, the experience of those who had not undergone surgery before this current one about surgeons is limited. As to whether their surgeries were perfectly done without complications, 75% of patients reported that the operations were perfectly done without any complications, while 25.0% reported that it was not perfectly done. This finding is in line with the reactions of the surgeons where larger percentage (59.5%) responded that all the surgeries performed by them were successful. This indeed is a sign that the surgeons carried out their surgeries diligently and efficiently.

However, the 25% of patients who were not satisfied with the surgeries carried out on them, have a point too. Something has to be done about that 25%, though no human being is a perfect human being and there is no perfection always on the performance of any job. But the advice here to the surgeons is to be more dedicated, committed, and be diligent in their performance of duties but if a mistake occurs along the line, it means God allows it. On the distribution of patients on the type of complications, they experienced; the results are a confirmation that the surgeons are carrying out their jobs very professionally. This is because 88.5% experienced only minor complications after surgery, while 11.5% reported major complications after surgery. This again is a case of majority carrying the vote. There is no perfection in anything. Human beings only have to try their best and if their best is not the best, there is nothing more they can do. On whether they were perfectly treated, 73.5% of the patients

reported that they were treated perfectly, while 26.5 reported that they were not treated perfectly. This further collaborated the finding of the surgeons.

As to whether there were complaints against the surgeons that operated on them; 71.5% of the patients reported that they had no complaints against the surgeons, while only 28.5% said they had complaints against the surgeons. This finding was in line with the reactions of surgeons where 91.5% reported that they had never been prosecuted for negligence. This is also expected about the 28.5% who had complaints against the surgeons, as there is no perfection in any human activity. On the whole, the surgeons performed their jobs satisfactorily. On the distribution of patients by assessment of the surgeon that did the surgery. 63.5% of the patients that did the surgery were good, 2.6% reported they were fair while 10.5 % reported that they were poor. This finding further supported the reaction of patients where they said they were being treated perfectly.

As to whether patients have idea of surgical negligence, 35.5% of the patients reported that they had idea of the issue of surgical negligence, while 64.5% reported they had no idea. This result accounts for why there is very low reported cases of surgical/medical negligence in Nigeria since people are ignorant of the issue of surgical negligence or medical negligence. This is a sign to confirm that there is not enough awareness on the basic rights and remedies available to patients for professional negligence. On the distribution of patients on how they would like negligence cases against a surgeon to be decided, 56.0% of patients opted for court decision, 14.5% opted for conciliation, while 29.5% prefer private settlement. The above results show that patients have much hope in the judicial system as the best means of litigating surgical negligence, even though when cases go to the law courts, the patients lose out on grounds of technicalities most often. On the distribution of patients by how they would think a surgeon

should be punished for negligence; 56.5% of the patients opted for prosecution as punishment for negligence; 35% of the patients reported that the surgeons should be made to pay compensation as punishment for negligence while 8.5% wanted them to be pardoned. This is a corroboration why larger percentage of patients opted for courts because they were of the view that they would obtain justice from the law courts when they report a negligence case but how has that been the case?

On the distribution of patients by whether they are aware of any existing law on medical practice; 35.0% of patients were aware of the existing law on medical practice, while 65.0% claimed that they were not aware of any existing law. This result shows that majority of the patients are ignorant of their rights regarding treatment. The implication of this is that cases of surgical negligence may happen without being reported.

On the distribution of patients by whether the interest of the patients are protected under the existing laws. The results show that 70.0% claimed they did not know whether their rights were protected or not, 14% reported that their interests were protected, 16% said they were not well protected. This result again shows that majority of the patients are totally unaware of their rights and privileges guiding their medical services under the law when the patients 70% do not know their rights, how then would they know if they were protected by the law? This means that something has to be done about this awareness lack.

Also, on the knowledge of the existence of the MDDC 32.0% said yes to the question while 68.0% said they were not aware. This result shows why majority of the patients would prefer to go to court because of their unawareness of this very important committee of the council. They would have preferred to go to the committee to report cases of surgical negligence

if they are aware. But again when one thinks that one would not get the desired justice at the end of the day given the way the courts had quashed most of the cases from the Disciplinary Committee, one would decline to go through the committee, rather would proceed straight to the courts. Some of the following cases were quashed by either the Supreme Court or the court of Appeal namely;

1. ***Dr Jeremiah Abalaka vs. MDDCN, and MDPIPl.***[294]
2. ***Miss Felicia Osagiede Ojo vs. Dr. Gharoro & Anor and University of Benin Teaching Hospital, Benin City***[295]***.***
3. ***Chairman, MDPIP vs. Dr. Osagie Onaiwu***[296]***, Charge No. MDPDT/29/2003, page 54;***
4. ***Chairman, MDPDT vs. DR. C.A. Obaseki,***[297] ***Charge No. MDPDIT/28/2003, P.4; and***
5. ***Chairman vs. Dr. Emmanuel Emelumadu,***[298] ***Charge No. MDPTD/23/2003 and so many others.***

The finding however, shows awareness lack as being embarrassing in this 21st Century, notonly to Nigeria but also to necessary institutions saddled with the responsibility of regulating medical practice and protecting the interest of patients in Nigeria.

On distribution of patients on whether they know they are entitled to some basic rights; 92% of the patients claimed they don't know they have some basic rights, while 7% of the patients said they had knowledge. The result shows high lack of awareness among patients and by implication, the society of their fundamental basic rights as patients. The result is not very

[294] Medical Law Report (2000) Part 2, Page 72 Tega Esabanor and Anor vs Dr. Tunde Faweya and ors, (2008), NWLR (Page 1102) 794.

[295] Ibid
[296] Ibid
[297] Ibid
[298] Ibid

encouraging. The question here is, how do we enlighten these patients or by implication the society in knowing their rights?. A lot has to be done here by the authorities whose responsibility it is to create the awareness to the populace. On the whole, the study discovered that majority of surgical patients were regularly checked post-operatively by the surgeons. This is contrary to the general opinion that people tend to have about surgeons and their patients. This finding is consistent with the expectation of the surgeons in Australia and New Zealand[299].

The study also discovered from the responses of the patients that the surgeons carried out their functions diligently and professionally. This discovery is in line with the expectations of the West African College of Surgeon's Guidelines on Surgeons Performance as well as Colleges of Surgeons all over the world. Majority of the patients experienced only minor complications, during and after operation. This finding is expected because of the handicaps in terms of equipment, facilities and environmental circumstances under which surgeons in Nigeria carry out their duties. The results of the study indicated that majority of the surgical patients were satisfied with the surgeries carried out on them.

This result tends to confirm the professional competence of the surgeons. The study also discovered that majority of the patients had little and no idea about surgical negligence. This is not a surprising finding given the level of illiteracy in the country and the terminologies and technicalities used in medical practice. Some patients also complained that they did not understand what some surgeons say when they come to them. They equally complained that some surgeons are always very impatient to listen to their complaints.

[299] Royal Australian College Of Surgeons Ette "A guide to and the assessment and Development of Surgeon 2011"

There is a need for the judiciary to demonstrate a high sense of uprightness and morality and give decisions which are in tune with the yearnings and aspirations of the people. Justice is not strait-jacketed or single-tracked. No, it is a multi-facetted traffic. The judges need to look into the jurisprudence of the matter and where indeed negligence has been discovered against the surgeons, or any other medical practitioner. They should not be spared in the area of award of damages. They should be made to pay the full extent that the justice of the case demands. In this vein, it is recommended that justice in this circumstance should not be sacrificed on the altar of technicalities. A situation whereby the dependant of a deceased is denied compensation (even after negligence has been established) just because he failed to show the amount of income ordinarily received from the deceased who died out of negligence of a hospital, is most deplorable. It is submitted that this is undue technicality which should not be used to defeat the ends of justice. This was exactly what happened in the case of ***Reverend Ali v. U.I.T.H. Ilorin***.[300]

6.10.3. Perception of Surgical Nurses on the Performance of Surgeons

A surgical nurse is one who possesses the requisite training, skill and knowledge to function as a surgical nurse. She must have qualified as a generally - trained nurse, obtained his/her RN, RM, B.Sc in nursing and midwifery, or Diploma in surgical nursing and/or theatre technique respectively. The surgical nurse is well qualified and has the necessary competence, skills and knowledge to work in all surgical wards, surgical clinics and theatre technique nursing. The role of the surgical nurse in the theatre is to assist the surgeons as scrub nurse and also performs other services in the theatre and in other surgical units. On distribution of nurses on how long they have been surgical nurses, 37.78% of them had been

[300]Supra.

surgical nurses for 2 -5 years; 28.89% has been for 6 – 10 years, while 33.33% of them had been surgical nurses for 10 years and above. On the distribution of Nurses by whether they had participated in surgery, 96.67% had participated in surgery, while 3.33% claimed they had not participated. As to the number of surgeries in which they had participated in, 26.67% nurses had participated in less than 5 surgeries, 25.56% had participated in 5 – 10 surgeries, while 47.78% of the nurses had participated in more than 10 surgeries. The corollary of the above information from the results pointed to the importance of nurses' involvement in surgeries and further showed that such nurses are in the best position to provide information on the assessment of surgeons' performance of their legal and professional duties to their patients.

As to whether all surgeries they participated in, were successful; the result shows that 42.78% of the nurses reported that all were successful, while 57.22% reported that not all were successful. The percentage of 42.78% is low compared with the reactions of both the patients and the surgeons. However, as low as the percentage seems, it shows some level of competence of the surgeons and calls for improvement on better services. With regards to the distribution of nurses by whether there were complications in some surgeries in which they participated; 69.44% experienced complications in some of the surgeries they participated in, while 30.56% had no complications in any of the surgeries they participated. This is in line with the responses of surgeons where larger percentage has responded to have experienced complications in surgeries.

As to how surgical patients are treated, 16.66% of the nurses reported they were perfectly treated, 55.56% reported that they were treated very well, 23.89% reported that they received good treatment, while 3.89% reported that they were treated fairly well. The summary of this

finding as to the treatment of patients by surgical nurses pointed to the fact that at least 100% of surgical nurses are okay with the treatment of surgical patients by surgeons. This is a credit to the surgeons. On the distribution of nurses on how to describe the attitude of surgeons in the theatre; 15.0% described their attitudes as very impressive, 47.78% described it as impressive, 35% described it as good, while 1.67% reported that their attitudes were unimpressive. The result revealed that a high number of the nurses have confirmed that their attitude in the theatre is good. It has to be good for them to work together otherwise, they will be throwing forceps to themselves and the theatre room environment would be a scary one for all of them. This is because they must work in the theatre as a team and if a team starts fighting itself, it should no longer work as a team but to disperse.

As to how nurses assess the level of commitment of surgeons to work; though, the nurses are not competent to assess the level of commitment of surgeons, because the surgeons are seniors to the nurses, however, a sort of advice to the surgeons when the nurses feel that things are not working fine, could make an input. In this result 33.89% said their commitment is impressive, 35.0% described it as good, while 5% reported it as unimpressive. All these supported the reactions of the patients that they are being treated well by the surgeons.

On the distribution of nurses by whether the environment is good enough for the safety of surgical patients; majority of the nurses reported that the environment was good, 93.33% of the nurses reported that the environment was good enough, while 6.7% said the environment was not good enough. This result is very good because the environment plays a major role in the recovery of surgical patients. This is also not unexpected since these are government

funded establishments, since access to good and enabling environment should be prioritized in a healthcare industry.

On the distribution of nurses by how diligent the surgeons are in the performance of their duties; it must be noted here also that the nurses are not competent to assess the diligence of the surgeons because the surgeons are their seniors. However the results are impressive. 7.78% of the nurses said that their performance were very impressive, 26.6% claimed they were impressive, 61.11% reported that their performance was good, while 4.44% of the nurses reported that they were unimpressive.

On the distribution of nurses by how they are satisfied with the level of compliance with the code of conduct by surgeons, 8.89% of them was very satisfied, 68.33 was moderately satisfied, 14.44% was dissatisfied, while 2.22% was very dissatisfied. This result revealed that surgeons are doing well in the performance of their duties though there are justification for improvement.

On distribution of how satisfied they are being surgical nurses, the result shows that 76.7% of the nurses were very satisfied, while 23.3% was moderately satisfied. On distribution of nurses on whether they have any idea about surgical negligence. The result revealed that majority of the nurses have idea of surgical negligence 85.6% said they had idea while 14.4% had no idea of the issue. This calls for concern for any nurse who is ignorant of surgical negligence. Nursing and medicine are all embraced in both medico-legal and ethico – legal issues. This then calls on the management of each health organization to organize some short term training programmes to embrace this issue of surgical/medical negligence among the

healthcare professionals because as the researcher had previously said in this thesis, to fore-warn is to fore-arm. Ignorance of law is never an excuse.

On distribution of how satisfied they are being surgical nurses, the result shows that 76.7% of the nurses were very satisfied, while 23.3% was moderately satisfied. Surgeons /medical practitioners should treat their patients well to enable them gain their confidence and love in order to avert certain litigations that may arise. The performance of surgeons should be improved upon. This can be done when the government takes good care of them, also through prompt payment of their salaries and allowances, provision of adequate medical equipment and increased awareness on the rights of patients and duties of surgeons. Structures should be put in place for ensuring that newly recruited surgeons are exposed to the technical skills and expertise of surgery. This is intended to enhance their performance and reduce possible incidences of surgical negligence. It is also recommended that even after recruiting the right calibre of surgeons, there is unassailable need to provide the right kind of environment within which they can function and up-to-date facilities such as functioning instruments and equipment should always be at hand to prevent excuses on medical negligence.

Equally, there should be legislation for upward review of conditions of their services every five years or less. The motivation in elevation and promotion as at when due will have the potency of infusing confidence of the surgeons and other health practitioners in the system and maximally reduce the issue of medical negligence. This is because, when the researcher interacted with some of the surgeons, they complained about the ineptitude of the government in meeting up with the demands of the health sector which they promised a long time ago. That accounted for the incessant strikes by the resident doctors in the health sector from time to time.

6.10.4. Post-Operative Management of Patients/Post-Operative Negligence.

Most cases of litigation in surgery emanate post-operatively. Post-operative case refers to the monitoring and subsequent receivers following surgery or treatment. Surgeons and surgical nurses are responsible for monitoring patients for complications that arise from surgery or treatment, preventing and treating infections, monitoring vital signs, giving detailed instructions to the patient for post- surgical, care and correctly prescribing medicines to the patient to aid the healing process and prevent complications. If a surgeon fails to properly monitor a patient or fails to notice symptoms of an oncoming injury that patient may suffer, the patient may have a viable negligent action against the surgeon and perhaps other health care team. Some of these types of infections, illnesses, and conditions that commonly arise post – operatively leading to surgical negligence include: viral infections, internal bleeding, infections at the site of surgery, tissue necrosis (dead,) organ perforation that went unnoticed, urinary tract infections (UTIS) staphylococcal infections, blood clots or pulmonary embolism, respiratory infections like pneumonia, peritonitis (infection of the peritoneal cavity) etc. If the surgeon and surgical nurses do not do their post-operative monitoring sufficiently, one or more of these listed above may also result in negligent suits depending on the intensity of the damage and type of patient(s).

CHAPTER SEVEN

CONCLUSION, FINDINGS AND RECOMMENDATIONS

7.0.0 CONCLUSION

Presently, the public are now being informed on matters of medical moral values and surgical litigation. Indeed, medical practitioners are being hailed as rescuers and saviours while at the same time condemned as pitiless. Therefore, as litigations against surgeons for negligence are rapidly increasing, surgical practitioners must learn to be cautious in the performance of their duties. The questionnaire survey on surgical practice and negligence evidently highpoints the ordeal in Nigeria and the duties of medical experts as well as the perceptions of patients on surgical mistakes. In this regard, this thesis has been able to highlight the main responsibility of a surgical practitioner which is to take good care and to find suitable treatment for the complaint of a patient in his care. This duty of a surgeon to exercise reasonable care has since been acknowledged from time immemorial. Therefore, once a surgical practitioner agrees to cure a patient, then a contractual relationship is formed.

Consequently, any deprivation of duty of care, negligence arises and the surgeon becomes liable to compensate the patient, if the patient is not dead or to his/her heirs. As discussed in this thesis, generally, medical competence rests on three major pillars that together established the foundation of independence of surgeons/medical practitioners. These are expertise, ethics and services provided. Expertise is a combination of knowledge and skills acquired overtime; ethical conduct flows from an exclusive combination of morals and values while service symbolises a professional obligation to put patients first. Moreover, independence

gives surgeons self-confidence which, inspiring them to do well with a solid sense of moral duty, to make an essential contribution to humanity.

Nonetheless, this thesis has shown that behaviours of surgeons/medical practitioners have to be controlled because there is a peculiar affiliation between surgeons/doctors and patients, who wholly depend on the expertise and skills of the medical practitioner. This means that patients have trust in their clinicians and permit them to encroach into their private lives and gains access to their private information.

As shown in this thesis, the action of a surgeon/medical practitioner can affect his patient in numerous means: from merely advising the patient on his life-style to doing harm in surgery for the treatment of the ailment. Thus, it is essential to ascertain surgeons who are not fit to practise as they may pose threat to patients for some notable reasons. Measures must be taken to stay them from working pending the time they would be cleared to do so. In other words, this thesis concluded that merely assuming that all surgeons/medical practitioners are qualified to treat patients would be dangerous and unethical.

Therefore, it is the duty of the profession to protect the patient against the incidences of medical carelessness in the interest of the populace. This is the more reason why the profession itself is required to agree to proper regulatory measures when persons do not act proficiently or morally. In Nigeria, while considering surgical/medical negligence, the Medical Practitioners Disciplinary Committee, is the regulatory body at work. The thesis has examined the set up and procedures before the Committee and on that basis it is concluded that the Committee has been doing well in terms of disciplining erring surgeons/medical practitioners.

The Nigeria medical council should lay down standards of fitness to practice and also to exercise discipline over the medical practitioners whose professional negligence is an

embarrassment to both the council and the entire professional bodies as was done in the case of *DR. (Mrs.) F.C.L. Olaye vs. Chairman, MDPIP and others*[301]

It is discovered that the Medical and Dental Disciplinary Committee is only concerned with serious matters of professional misconduct and does not provide any protection for the public. The courts also, in cases of permanent harm or disability applies the panel sanction on the criminal aspect of that acts as a punishment and has a deterrent effect also, but the victim is left without any compensation what so ever. The penalties or fines only go to the state and if the victim wants, can now apply for a civil action. This is not right for a victim that has suffered traumatic period. The court is urged then to award compensation to the victim directly as well as the punishment to the offender. This is important and will reduce extra pain and financial resources from the victim that has suffered damage.

As shown in this thesis, the knowledge on medical negligence is lacking without knowing its legal foundation. That is, in order to establish surgical negligence case and ask for compensation, there is the need to invoke the tort law, which is the basis of this subject. The three elements for establishing surgical/medical negligence in medical lawsuit are: duty of care, breach of duty and causation/damage. It is the conclusion in this thesis that for a claimant to succeed in the legal battle, the three elements must be proved. As indicated in this thesis, the Bolam Test and the Bolitho case have shaped the keystone in judgments.

The Bolam Test essentially based the standard conduct of a surgeon/medical practitioner by relying on the standard conduct of his colleague at the time of incident. Under the Bolam Test, a surgeon is not careless if what he has done is acknowledged by a particular body of medical opinion; though such opinion must rest on a commonsense. However, an exception happened in the case of Bolitho when the damage to the patient was so much that the court found

[301] (1992) 6 NWLR. 553

it hard to conclude the act of the respondent as rational notwithstanding that the doctor was supported by his colleagues. The submission to Bolam Test makes life simple, but eventually unfair as medical experts tend to shield their associates. Equally, the upturn of Bolam may lead to judges deciding on unskilled medical matters that are hard to understand thereby leading them to practice self-defensive medicine.

In spite of the dispute in court for litigation, bad communication is being identified as the key problem in many cases dealt with by the Medical Council. In reality, time pressures and the strains of job make it hard to give patients satisfactory time and care they deserve. However, surgeons with bad communication skills or who are bad-mannered and big-headed are more perhaps to be the focus of a claim when patients are not satisfied with their services. In other words, patients seem to sue persons they dislike, whom and who cannot apologise for offenses committed against the patients. Therefore, the best advice to surgeons/medical practitioners is to engage with patients and to treat them well. Indeed, there is no obvious link between medical expertise and susceptibility to grievances and claims.

In fact, some less clinically skilled surgeons could go through their entire profession without facing a legal or disciplinary encounter. That was part of what the researcher discovered. Therefore, good communication between surgeons and patients would result into a better knowledge of the nature of ailment, know the treatment models and likely impediments capable of arising there from. Thereby, establishing a worm relationship between the surgical patient and the surgeon.

Through judicial analysis, the shortfalls in medical practice were listed seriatim. In the course of this work, the Bolam Test and the Bolitho principle have been the guiding rules depending on the jurisdictions. However, one thing that is very certain through the available judicial decisions

analysed in Nigerian court is the fact that the Nigerian courts are yet to come up with her own basic principles for determining surgical/medical negligence and as such much burden is being placed on the plaintiff. Over all, the investigation conducted in this thesis has examined the scope of professional work as it relates to medical practice, specifically, surgeons, the up keeping of standards and the sanctions in case the standards fall below the satisfactory level. In case the standards fall below the expected level, the aggrieved party may approach either the court or the regulatory body for proper remedies. Therefore, the issue of professional negligence of a surgeon would arise where a complaint is made to the court. However, prosecuting an action in court is with notable challenges as earlier indicated in this thesis and as such plaintiffs usually feel aggrieved because the legal procedures seem to be laborious and, sometimes, insurmountable obstacle. It is on this premise that some notable recommendations were made to ensure balance in the dispensation of justice and enhance access to justice in negligence cases relating to medical practice.

The researcher wish to therefore, conclude this thesis with the quotation by ***MAHATMA GANDHI*** **about (A CUSTOMER), in** Medical Negligence for Doctors, Patients and Hospitals, Should Know, in Shenoy P. D. 2003 which says:

> *A customer is the most important visitor on our premises, he is not dependent on us. We are dependent on him he is not an interruption in our work, he is the purpose of it. He is not an outsider in our business. He is part of it. We are not doing him a favour by serving him. He is doing us a favour by giving us an opportunity to do so.*[302]

7.1.0 FINDINGS

The findings of this thesis revealed that:

a. The surgeons are quite aware of their legal duties to the surgical patients;

[302] (2003) MAHATMA GANDHI in Shenoy P. D. **"**Medical Negligence for Doctors, Patients and Hospitals Should Know".

b. In spite of the overwhelming awareness of the legal duties of surgeons on surgical patients, the study revealed the need for the surgeons to cater more for the interest of their patients;

c. The existing laws on surgical negligence in Nigeria to some extent are indeed commendable, but there is the need for amendments to the existing law on surgical negligence or in the alternative, a comprehensive law to regulate surgical practices in Nigeria;

d. The regulatory body has been to a very great extent effective in dealing with erring surgeons. However, surgical patients are quite unaware of its existence, i.e. the MDPCN to which the surgeons belong;

e The populace has so much confidence in the judiciary, yet when their cases reach the court, they are quashed on flimsy technicalities and make access to justice a difficult task for surgical patients, in spite of the so much hope of the patients on the judicial system.

f The level of awareness of surgical patients as to their basic rights are grossly inadequate.

g Bad communication from surgeons to their surgical patients.

h When the surgeon commits an offence against a patient, it is very difficult for him/her to apologise. Apology plays a great role of soothing nerves as the researcher had discussed in chapter 6.

i The percentage of the surgeons who are aware of their legal rights to patients, is quite high. In spite of this high awareness some surgeons still play on their rights

j That some surgeons delegate registrars to do major operations unsupervised, which could lead to harmful and unprecedented deaths at times. Such was the case in *Olajuwura Onidundu vs. University College Hospital Ibadan*[303]

k Cases of surgical negligence abound, but patients cannot report or litigate because of: (i) poverty (ii) length of litigation process which is high.

l There is need to open up other doors of complaints on surgical negligence for surgical patients;

m There exists lack of avenues to create awareness on the rights of surgical patients, especially amongst the Nigerian Muslim patients, who believe that for any medical mishap that occurs, is as a result of Allah's will.

n Even those who try to litigate, end up withdrawing their cases after being frustrated by the length of time or period of litigation, in such cases, they end up going for A.D.R. for the settlement of their disputes. They do not like to hear about the conduct of post – mortem examination on their dead relatives to help decide their cases.

7.2.0. RECOMMENDATIONS

In order to lessen the occurrence of surgical negligence and its damaging impact on both the patients and the surgeons, the following recommendations are proposed:

a. There should be an improved communication between surgeons/medical practitioners and surgical patients in order to really understand the nature of illness and the appropriate treatment;

[303] (2002) (Unreported) Easy law "Online" 9th June, 2011. This Day Live Newspaper on the 9th of August, 2011. Facts of the case. A 29yr old Olajuwura, lived

b. There is a need to improve on ethical education for students of medicine and also enhance public education and awareness, for better understanding of the culture of medical practice in order to abreast them with the update of laws governing practice of medicine in Nigeria and thereby lessening the incidence of surgical/medical negligence. To achieve the above could be by way of organizing short-term courses, for medical practitioners on medico-Legal or ethico-legal issues for proper care towards their patients.

c. There is the need to reform the law of tort in Nigeria. This is because, the usual way for seeking redress for damage suffered resulting from surgical negligence is the tort system, which has increasingly been subjected to criticisms.

d. That in the dispensation of justice, the court should dispense with technicalities as many cases have been set aside on such grounds and claimants went home with nothing. This was the case in *Rev. Alli vs. UITH Ilorin*[304] decided in Ilorin High Court Kwara State, by Olagunju J. (as he then was)

e. Surgeons in Nigeria should engage themselves in self-development to acquire new technology, broaden their knowledge and sharpen their skills in surgery to improve their work in order to reduce surgical patients' long stay in the hospital;

f The existing laws on the legal rights of patients and duties of surgeons should be strengthened to improve its effectiveness. This can be done by mainly creating more awareness on these rights to the surgeons and to patients and by strengthening the existing institutions.

[304]Suit No KWS/94/91, 29/9/97.

g There should be a legal health audit committee to monitor the performance of surgeons and other health care professionals on routine basis. This would reduce possible carelessness and negative attitude of some surgeons.

h. There is a need for increased enlightenment, awareness campaign and education for the public on surgical negligence. These will enable them know when their rights as well as patient's rights are breached and also help them seek redress in appropriate quarters.

i. It is further recommended that there should be a functional insurance scheme established to enforce and implement the rights of patients and to cater for victims of surgical negligence. This scheme can be founded and funded by the government through the hospitals whether public or private hospitals;

j. There is a need for the Nigerian Consumer Protection Agency to create awareness on its legal duties and responsibilities to patients on health-related disputes.

k. This study did not look into the depth of surgical negligence in some Nigerian hospitals, So, there may be the need for further study in this area. It is the researcher's belief that the outcome of this study has added to the existing body of knowledge in surgical negligence;

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