TORTIOUS LIABILITY OF MEDICAL PRACTITIONERS IN NIGERIA: AN APPRAISAL

BY

ISHAK BELLO

APRIL, 2000.

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF LAWS (LL.M.) OF THE FACULTY OF LAW AHMADU BELLO UNIVERSITY, ZARIA, NIGERIA.

APRIL, 2000.

DECLARATION

I Ishak Bello, hereby declare that this thesis has been written by me and it is a record of my own research work. It has not to the best of my knowledge, been presented or published any where at anytime by anybody, Institution or Organization. All quotations and references are duly indicated with specific acknowledgements. However, I remain solely responsible for views expressed and all the deficiencies therein.

I
shak **Bello**

Ahmadu Bello University,
Zaria - Nigeria April 2000

CERTIFICATION

This Thesis entitled, "Tortious Liability of Medical Practitioners: An Appraisal," by Ishak Bello, meets the regulations governing the degree of master of Laws (LL.M) of the Faculty of Law, Ahmadu Bello University, Zaria-Nigeria, and is approved for its contribution to Knowledge and literary presentation

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DEDICATION

This thesis is dedicate to my late parents, Alhaji Bello Areo Sabon Kudi and Hajiya Raliya Bello whose love, care and constant prayers brought me to what I am today. May the Almighty God grant them eternal rest.

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ABBREVIATIONS

A	WACA
A.L.R.	
A.N.L.R.	
C.C.H.C.J	
E.R.N.L.R.	
FRCLR	
FSC	
GLR	
LLR	
LRN	
NLR	
NMLR	
NNLR	
NRNLR	
NSC	
NWLR	
S.C	
SCNJ	
SSCNLR	
UGLR	
UILR	

NIGERIA	Law Reports
N AND	Federal revenue Court Law Reports
OTHER	Selected Judgment of the Federal Supreme Court
AFRICAN	Ghana Law Reports
LAW	Lagos Law Reports
African	Law Reports of Nigeria
Law	Nigerian Law Reports
Reports	Nigerian Monthly Law Reports
All	Northern Nigerian Law Reports
Nigerian	Northern Region of Nigeria Law Report
Law	Nigeria Supreme Court Cases
Reports	Nigerian Weekly Law Reports
Certified Copies of	Judgment of the Supreme Court
High Court	Supreme Court of Nigeria Judgments.
Judgemen t	Law Reports of the Supreme Court of Nigeria
Eastern	University of Ghana Law Reports
Region of	University of Ife Law Reports
Nigeria	Selected Judgments of the West African Court of Appeal

WNLR	-	Western Nigeria Law Reports
WRNLR	-	Western Region of Nigeria Law Reports

B. UNITED KINGDOM LAW REPORT

AC	-	Appeal Cases
ALLER	-	All England Reports
APP.CAS.	-	Law Reports, Appeal Cases
Ch.D	-	Law Reports Chancery Division
E.R	-	English Reports
K.B	-	Law Reports, King's Bench
LJ.CH	-	Law Journal, Chancery Reports
LR.Exch	-	Law Reports, Exchequer
L.T	-	Law Times Reports
PC	-	Judgments of the Privy Council
QB	-	Law Reports, Queen's Bench
TLR	-	Times Law Reports
WLR		Weekly Law Reports

ABRSTRACT

This thesis entitled, "Tortious Liability of Medical Practitioners in Nigeria: An Appraisal," Examines critically, the civil (tortious) Liability of Health care providers in Nigeria. In Nigeria, there is very little awareness that medical professional duties carry legal implications. The conduct of professional people in the medical field, positive or negative, does not only affect their employers but impact directly on third parties. Consequently, liability will arise both against the employer and the employee professional, in the event of a broach of duty by the latter to act with reasonable care and deligence. The Law is therefore, well settled that medical men owe duty in tort, i.e. civil wrongs to their patiens whether there is a contract with the patient or not.

Unfortunately, this aspect of the laws is not properly exploite in Nigeria especially in the Northern part, due to low level of awareness and cultural norms in which every mishap is attributed to God's will. Secondly, the cost of litigation is high and even with the undeveloped Legal Aid System in Nigeria, not everybody is eligible for legal aid. And lastly, doctor - patient relationship evidence has shown that family doctors are less likely to be sued as theey are more likely to have relationship of trust with their patients. Nevertheless, the law of medical malpractice has come to stay in Nigeria even though litigation is on small scale. Victims of medical malpractices have brought actions against medical practitioners in Negligence, criminal law, and in trespass in Nigerian Courts, especially in southern Nigeria.

This work starts with an introductory chapter which discusses the objectives of the thesis, its sccpe, the method by which the research is conducted and the organizational Layout of the thesis.

Secondly negligence is discussed as the basis of liability of medial practitioners. Under this, the nature of negligence of medical practitioners is discussed and some instances of civil medical malpractice analysed properly. And finally the liabilities of quacks and native doctors are also ciscussed.

Thirdly trespass and criminal liability of medical practitioners, as well as the liability of hospital managements, are discussed.

Fourthly the defences and remedies to tortious liability of medical practitioners, in Nigeria are examined.

And finally, we have the summary (Conclusion) and Suggestions for reforms in the area of medical malpractice law, especially the tortuous aspect in Nigeria.

CHAPTER ONE GENERAL INTRODUCTION 1.1

Introduction.

This thesis entitled "Tortious Liability of Medical Practitioners in Nigeria: An Appraisal seeks to examine critically, the civil (tortuous) liability of health care providers such as, doctors, dentists, pharmacists, laboratory technologists and technicians, radiologists and radiographers, anesthetists, ward attendants, hospitals etc. In order to do this, the tortious liability of each group of personnel, is not going to be treated separately but rather as one body (medical practitioners). In Nigeria, there is very little awareness that medical professional duties carry legal implications. The conduct of professional people, in the medical field, positive or negative, does not only affect their employers but impact directly on third parties. Consequently, liability will arise both against the employer and the employee professional, in the event of a breach of duty by the latter to act with reasonable care and diligence. The Law[1] is, therefore, well settled that medical men owe a duty in tort, i.e., civil wrong to their patients, whether there is a contract with the patient or not.

Unfortunately, this aspect of the law is not properly developed or again properly exploited in Nigeria especially in the Northern part of Nigeria, due to low level of awareness and cultural norms in which every mishap is attributed to God's will[2]. Secondly, the cost of litigation is high and even with the undeveloped Legal Aid system in Nigeria, not everybody is eligible for legal aid. And lastly, Doctor - patients relationship; evidence has shown that family doctors

are less-likely to be sued as they are more likely to have a relationship of trust with their patients. Nevertheless the law on medical malpractice has come to stay in Nigeria even though litigation is on a small scale. Victims of medical malpractice have brought actions against medical practitioners in Negligence,[3] in Criminal Law,[4] and in trespass in Nigerian courts, especially in Southern Nigeria.

It should be noted that this introductory chapter also discusses objective and scope of the thesis, the research methodology and the organizational layout of the research. Nigeria has been chosen to limit the scope and secondly, because the Author, is an employee of a Teaching Hospital These two circumstances present an ideal situation for the realization of the objectives envisaged by this research. 1.2 **Objectives of The Thesis**

The aim of this research is to identify the categories of personnel involved in the practice of medicine in Nigeria and determine their tortious (civil) liabilities for malpractices committed in the course of carrying out their duties. In Nigeria, there is very little awareness that medical professional duties carry legal implications. This accounts for the fact that in Northern Nigeria, there have been little or no litigation arising from the activities of health care providers, such as physicians, dentists, nurses, among others. The aim of this thesis, therefore, is also to create awareness not only on the part of health care providers at all levels that they must have a clear appreciation of the basic legal responsibilities of neir jobs but also, on the part of health care recipients that they have a right of redress in law against any health care provider who perpetrates professional

malpractice on them. The activities of medical professionals, positive or negative, do not only affect their employers vicariously, and themselves, but impact on third parties. Consequently, liability will arise both against the employer and the employee professional, in the event of breach of duty by the latter to act with reasonable care and diligence.

The tortious liabilities of medical practitioners in Nigeria will be discussed based on negligence and trespass. This of course will depend on the act or omission leading to the injury. To achieve this objective, there shall be a detailed analysis of the necessary applicable statutory laws, restatement of legal rules and analysis of cases in both the Nigerian and other jurisdictions where the principles of law are similar. It is hoped that at the end of this research there will be rise in awareness and literacy level and therefore there will certainly be rise in litigation and the like on medical cases in Nigeria, as it happens not only in the south, but worldwide.

1.

3. SCOPE OF THE THESIS

Geographically, the thesis will cover the Federal Repuplic of Nigeria comprising Thirty-six states. Historically and legally, the research shall cover the

laws of medical malpractice in Nigeria during and after colonization, up to the present date, especially, the law of torts. The legal coverage of this thesis is centered around the inherent problems of medical malpractice in Nigeria, that is, the legal responsibilities of the healthcare deliverers and the rights of their patients. As it was said earlier in this chapter, this area of the law is still largely undeveloped because of illiteracy and lack of awareness on the part of health

care providers and the recipients alike, as well as religious beliefs on the part of most victims of medical malpractice, especially from the Northern part of Nigeria. In order to make a considerable impact on this thesis on the tortious liability of medical personnel in Nigeria, there is need for proper analysis of the available literature and cases, restatement of legal rules and recommendations for reforms in this area. 1.3 **Research Methodology:**

This research is certainly not the first work on this area of the law in Nigeria, and may not prove better than the existing ones either. This thesis will, therefore, review the existing rules on the tortious liability of medical practitioners in Nigeria, with a view to making useful suggestions for reforms in this area. As the rules on medical malpractice are virtually settled, an extensive tour will be made, not to ascertain the rules, but rather to assess the extent of medical malpractices, the degree of awareness of legal responsibilities on the part of medical practitioners or again the health care deliverers and, on the other and, the degree of awareness of the legal rights of the patients in torts, and their attitudes towards litigation.

Another method to be adopted in this research will be firstly, to discuss in detail and examine rules and decided cases on the subject matter as are available in the libraries. Originality shall therefore, lie in the appraisal of the existing rules, identifications of defects in the rules and suggestion for reforms.

Questionnaires shall be prepared and administered extensively within the geographical area of this research. The aim is to assess the rate of medical

malpractice, the level of awareness of legal responsibilities of the health care deliverers and the awareness of the health care recipients of their tortious rights and their attitudes to vindication. It is hoped that the result of the questionaire will form an essential part of the bases for suggestion for reforms in this area of the law in Nigeria.

An acute problem to be faced by the Author is that of authorities, especially Nigerian decided cases, which are very few. The reasons for the paucity of Nigerian cases in this regard are that: (1) There is fear probably by the courts that many successful actions may lead to medical malpractice crises, leading to defensive medicine. Defensive medicine is medicine practiced not for the benefit of the patient, but to protect the doctor from litigation, such as, rise in number of caesarean section births as opposed to natural births[7];(2) Cost of litigation is high. In Nigeria, poverty rate is very high. Most of the victims of medical malpractice are poor people who cannot engage the services counsels to argue their briefs or even pay court charges. Although some Lawyers in Nigeria accept to work on a contingent fee system, not all patients are able to identify them. A contingent fee system is a system whereby the lawyer undertakes to handle a brief without any prior payment of fee by the client, if the client, if the client at the end of the litigation receives nothing, the lawyer receives no fee, but in a successful case, the lawyer receives an agreed percentage of the damage; (3) The legal Aid System in Nigeria is not very effective and not everybody may be eligible for Legal Aid. So the client has to fund the action himself and risk not recovering cost. There is also the Doctor - patient

relationship. Evidence has shown that family doctors are less likely to be sued as they are more likely to have a relationship of trust with their patients[8]; Most patients especially in the Northern part of Nigeria, do not have compensation awareness and finally; (5) the cultural or religious norms especially in Northern Nigeria, in which every mishap is attributed to God's Will.

However, since the general principles of law governing tortious liability of medical practitioners all over the Common Law world are similar, decided cases from other Common Law countries will be employed. It is to be noted that, whever reference is to be made to such cases or authorities, they must reflect directly on a similar point to be discussed or explained or illustrated under tortious liability of medical practitioners in Nigeria. Reference shall also be made to other legal systems whenever the need so arises. 1.5 **Organizational Layout of the Thesis**

Chapter one of this thesis is an introductory chapter, which discusses the objectives of the thesis, its scope, the method by which the research shall be conducted, the organizational layout of the research.

Chapter two proposes to discuss Negligence as the bases of liability-of medical practitioners. In this chapter the nature of negligence of medical practitioners shall be discussed and some instance of civil medical malpractice analyzed properly. And finally the liabilities of quacks and Native Doctos shall also be properly analyzed.

Chapter three shall discuss trespass and criminal liability of medical practitioners, as well as, the liability of hospital management.

Chapter four proposes to deal with defences and remedies to tortious liability of medical practitioners in Nigeria.

Finally, Chapter five shall be the summary (Conclusion) and suggestion for reforms in the area of medical malpractice law, especially the tortious aspect in Nigeria.

I

Notes and references

1. Clark and Lindsell On Tort 14th Edition Paragraph 9 9121 and Q13Pg. 541
2. This was obtained from the questionnaire.
3. See the Cases of Kanu v. Dr. E.S. Etuk (1922), 6 E.N.L.R. 196. And Denloye v. Medical Practitioners Disciplinary Committee (1994) 8. N.W.L.R. PT. 363, 367, at 395, 396.
4. See the case R.V. Akerele (1941) 7 W.A.C.A. 56.
5. Ahmadu Bello University, Teaching Hospital, Zaria - Nigeria.
6. John Cooke, Law of Tort, Pitman Publishing London, 1992, P. 155.
7. This is the result of the questionnaires.

CHAPTER TWO

NEGLIGENCE A3 THE BASIS OF LIABILITY

OF MEDICAL PRACTITIONERS

2.1 Introduction:

This chapter shall discuss the nature of negligence of medical practitioners and, some instances of tortious medical malpractices properly analyzed. The civil or tortious liability of quacks and native doctors shall also be properly analyzed, with a view to making useful suggestions. Meanwhile, before the Chapter begins properly, a medical practitioner may be defined as anyone who holds out himself as a person who undertakes the cure or treatment of human ailments, or anyone who undertakes to provide health care delivery.

2.2 The Nature of Negligence of Medical Practitioners.

According to Alderson B., in Blyth v. Birmingham Water Works Company Co. (1856)[1] "Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would do, or doing something which a prudent and reasonable man would not do." Simply put therefore, "negligence is the breach of a legal duty to take care which results in damage, urdesired by the defendant to the plaintiff."[2] Negligence in medical practice ordinarily implies that the medical practitioner had the consent of his patient to treat him, but such treatment did not conform with the standards imposed on the medical practitioner by law. An action in negligence involves three basic elements: (1) the nature of the duty that the law

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

The courts generally regard the relationship between patients and medical practitioners as contractual[3]. When a patient presents himself to a medical practitioner for medical care, and the medical practitioner proceeds to render that care, the law implies that a contract has arisen between the parties. It is from this contractual relationship that the duty of the medical practitioner to his patient arises. In medical professional liability litigation, the trend has been for the patient to bring suit against the physician for alleged failure to use reasonable care and that action is usually in tort. According to Halsbury's Law of England,[4]

> A person who holds himself out as ready to give medical advice or treatment impliedly undertakes that he is possessed of skill and knowledge for the purpose. Such a person, whether he is a registered practitioner or not who does a patient, consult, owes him certain duties, namely, a duty of care in deciding what treatment to give and a duty of care in the administration of that treatment. The practitioner must bring to his task a reasonable degree of care. Neither the very highest, nor very low degree of care and competence judged, in the light of the particular circumstances of each case is what the law requires; a person is not, liable in negligence because someone else of greater skill and knowledge would have prescribed different way; not is he guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art, although a body of adverse opinion also existed among medical men.

The quotation above is a precise epitome of the essentials of the negligence of medical practitioners. This is a clear indication that a practitioner stands the risk of paying compensation at any time he acts below the standard required of a competent practitioner of his class, experience and circumstance[5]

Consequently, if a medical practitioner holds out himself as a good surgeon, he must measure up to the standard generally approved or acceptable in the field of surgery (not a specialist in a particular area of medicine), then he is accordingly expected to measure up to the generally acceptable standard for general practitioners[6]. Therefore, the standard is not constant; it is dynamic and changes in accordance with the area of specialization of each doctor. Differences in circumstances and facilities at the place of work may also affect the standard required in each case. Thus, more efficient medical services may be expected. in a modern well-equipped hospital than a village medical center.

Under this head, we shall consider proof of negligence in civil liabilities of medical practitioners and some instance of negligence (Civil liabilities) of medical practitioners. 2.2.1 **Proof of Negligence in Civil Liabilities of Medical Practitioners.**

The quantum of proof in civil action is a preponderance of probability. The plaintiff has to adduce evidence to show that the medical practitioner was negligent. Generally, in medical malpractice cases, it may be difficult for the patient plaintiff to prove negligence because he may not know what happened. In view of this difficulty of direct proof of fault and of the causal nexus between the fault and injury, the court may allow the plaintiff to rely on the doctrine of Res Isa Loquitur[7]. Literally, this maxim means, "The event speaks for itself". In its inception, Res Ipsa Loquitur was nothing but a reasonable conclusion from The circumstances of an accident that, the accident was probably due to the defendant's fault,

In England, however, the decision in Mahon v. Osborn", raised the issue whether the rule of res Ipsa loquitur only applies if the event is a matter of common experience, so that special experience of an expert is irrelevant. Boddard L.J. held that the doctrine applies where swabs have been left in the body of a patient after an abnormal operation[9]. But Scott L.J. thought that where the judge would not have enough knowledge of the circumstances to draw an inference of negligence, as in the case of surgical operations, the doctrine did not apply[10]. However, the Court of Appeal has held it to be prima facie evidence of negligence that a man, on leaving hospital after a course of radiography treatment to his hand and arm, had four stiff fingers and a useless hand[11].

There are further requirements which must be supplied for the rule of res Ipsa loquitur to apply, that, the plaintiff must prove not only that, (1) the event is of the kind that ordinarily does not occur in the absence of someone's negligence, but also that it was caused by an agency or instrumentality within the exclusive control of the defendant. This is illustrated by the case of Scot. v. The London St Katherine Dock Co.[12], where bags of sugar fell on the plaintiff, while he was lawfully passing the doorway of the defendant's warehouse. The defendants called no evidence. Erie C.J. said:

> There must be reasonable evidence of negligence, but where the thing is shown to be under the management of the defendant or his servant and the accident is such that in the ordinary course of things does not happened if those who have the management use proper care, it affords reasonable evidence in the absence of explanation by the defendants, that the accident arose from want of care.

(2) The second requirement is that the accident was not due to any voluntary action or contribution on the part of the part of the plaintiff[13]. The effect of the last

condition is that it may create some problems because the plaintiff is normally unconscious and does not know what he or the defendant happens to be doing. His natural bodily reaction or condition, which may have contributed to the final harm, is certainly neither wilful nor controllable or observable by himself in most cases and yet can absolve the medical practitioner from responsibility. It is therefore recommended that, the last condition should be abrogated. 2.2.2. **Instances of Negligence (Civil Liability) of Medical Practitioners.**

If a medical practitioner performs treatment to a patient in a way or manner, which is negligent, and thereby causing harm to the patient, the patient may institute an action against such a doctor to recover damages for harm suffered. Liability for negligence can only arise where there is a legal duty to take care either in contract or in tort[14]. This implies that for the plaintiff to succeed. in his case, he must prove that the doctor was negligent and this onus stands discharged if he can show that: (a) the doctor owed him a duty to use reasonable care in treating him; (b) that the doctor had failed to exercise such care, that is to say that he was in breach of that duty and; that the had suffered damage or injury as a result of the breach[15]. He needs not show that there was agreement between him and the doctor to avoid causing damage or harm before succeeding in his case. Authority for this proposition is the case or R. v. Bateman 16. in that case, the appellant a panel doctor practicing in one town called Deptford, was convicted of manslaughter of a patient call Mary Ann Harding and was sentenced to six months imprisonment by the trial court for criminal negligence. He had actually been called in to attend to the patient on her confinement. After finding

that her case was a difficult one, he first attempted unsuccessfully to make her deliver by the use of instruments, after administering Chloroform; he then tried perform manual operation called "version", after an hour the child was born dead. Five days after the delivery of the child the patient was then very seriously sick and was removed to the infirmary, where she died two days after. The charges preferred against him and for which he was convicted were: (a) that in the performing of "version" he had occasioned an internal rupture; (b) that with the placenta he had removed part of the uterus and; (c) that he had unduly delayed in sending the patient to the infirmary.

On appeal, his conviction for criminal negligence was quashed and was instead convicted for civil negligence. The court, then observed with regards to civil liabilities of doctors as follows.

> If a person holds himself out as possessing special skill and knowledge, and he is consulted as possessing such skill and knowledge by, or on behalf of a patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward[16].

Going by the above quotation, it becomes obvious that no contractual relation is necessary, nor is it a requirement that the service be rendered for reward. This means that the plaintiff in a malpractice suit needs not prove the existence of a contract or that the service was rendered in expectation of a certain reward promised before he can succeed. The reason for not making contract a condition for doctor's liability in negligence is not unconnected with the fact that there are two ways in which a doctor may be held liable to his patient; one is through

contract and the other is through tort. This means that if there is an agreement between him and the patient as to how to go about with the treatment, his liability may be based on breach of that contract. But where there is no contract, the his liability will be in tort. Therefore, here, the criterion it has been submitted is that since he is engaged in a kind of work that involves endangering some one's life, he is then automatically under a duty of care not to do anything that will cause someone, his life[17].

There are many instances of civil liability or liability in negligence of medical practitioners. Some of the instances, which we are going to consider here are; improper diagnosis, treatment, drugs, x-ray injuries, anaesthesi surgery, blood transfusion and abandonment.

2.2.2.1 **Improper Diagnosis**

The mere fact that a physician has made an error in diagnosis is not enough, by itself to support a claim that he was negligent. A physician has a duty to use ordinary care and skill necessary to acquire all available data essential to a proper diagnosis. The patient is entitled to a careful examination as his condition and the circumstances will permit, with the exercise of such diligence and the application of such methods of diagnosis for discovering the nature of the ailment as are usually utilized by medical men of ordinary judgment and skill in that community or in similar localities[18]. First case, which relates to improper diagnosis, is the case of Pundey v. Union - Castle Mail S.S. Co. Ltd & Anor[19]. In that case, the plaintiff, a member of crew of the first defendants' steamship called Llaustephan Castle fell sick, complaining of

rheumatism while they were on voyage from London to the east coast of Africa, via Cape Town. He was then examined by the ship's doctor, the second defendant, who prescribed treatment for him and also recommended that he be repatriated. The plaintiffs health further deteriorated. He was again examined by a specialist who discovered that the plaintiff was suffering from acute arthritis. The plaintiff them brought an action against the first and second defendants claiming damages on the grounds that the second defendant was negligent in his diagnosis and treatment. Evidence of a similar symptom of rheumatism by other doctors who examined him before his repatriation was however adduced.

The court held that the plaintiff, had not only failed to prove that the second defendant was guilty of any lack of care in his diagnosis or treatment but that, taking into account the symptoms then observed by him and his fellow doctors, the medical evidence confirmed that he had in fact prescribed the correct treatment. Even though the decision of the case as in favour of the defendants, it still demonstrates the principle that where a doctor is found to be negligent, he can be made to pay damages to the plaintiff for any injury he may have suffered as such. The medical practitioner in the above case escaped liability because there were evidences from other doctors who had examined the plaintiff before, showing similar symptoms of rheumatism; otherwise, he would have been found liable.

Where the facts and circumstances of a case show that there was an unequivocal instance of poor diagnosis, the courts are always ready to yield to the deserving cases. Thus, In Fortner v. Koch[20], the plaintiff came to the

defendant physician with a swelling on his knee and additional symptoms that might lead a physician to suspect a variety of conditions. The physician examined the patient manually, placed him on a diet, and injected a solution into his bloodstream. Severe injuries followed. It was shown at the trial that the usual practice among physicians in the community under these circumstances was not only to take the history of the patient but also to make an x-ray study, a blood test an a biopsy. These were not considered alternate tests. All of them were required. The defendant was held guilty of negligence for failing to make these diagnostic tests. In another case, Meyers v. Clarkin[21], there was evidence that the surgeon diagnosed the case as a fracture of the upper third of the femur but failed to notice and or treat a break of the neck of the femur. This oversight resulted in additional operations and injuries. The physician was found guilty of professional negligence. In yet another case, Harriott v. Plimpton[22], a physician was held liable for making an erroneous diagnosis of a venereal disease, which led to the breaking of an engagement to marry. Even in Nigeria, it was found through interviews that there are rampant cases of poor diagnosis, leading to death and aggravation of illnesses, but the victims hardly realize them and even when they do relies them, they do not litigate. This is so because most patient are poor and cannot cope with the heavy cost of litigation and others especially the Muslims from the Northern part who believe that every mishap is as a result of the will of God, which no human being stands to challenge. It is recommended that victims of medical negligence should always go to court to vindicate their rights. This will shape the conduct of unruly health care deliverers.

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2.2.2.2. **Improper Treatment**

A medical practitioner is neither a guarantor not an insurer of good result of a cure. The art and science of medicine, being what they are, there will always be poor results from treatment despite the fact that the highest degree of care is given. Thus, the poor result is not usually evidence in itself of negligence on the part of the medical practitioner. These principles were applied in the following cases. In Camon v. U.S23, civilian was on, in an Army hospital for varicose veins. An infection followed the operation and developed into a phagedenic ulcer, a rare and serious disease. It was held that the physician and the United States were liable for negligence. In yet anothe case, Chin Keow v. Government of Malaysia[24], a doctor administered an injection of procaine penicillin to a woman as a result of which she died within an hour. Her mother sued in negligence alleging that the doctor had failed to inquire conduct any test to ascertain whether the woman was allergic to penicillin or not before injecting her with it. And that if he had conducted the test or made the inquiry, he would have found out that the woman had previously reacted badly to penicillin as a result of which her out patient card was endorsed with the warning Allergic to penicillin". The trial judge then held that the defendant was liable in negligence for failing to make the inquiry or conduct the tests. On appeal to the Federal Court of Malaysia, the finding of negligence was rejected. On further appeal to the Privy Council, however, the decision of the trial court was restored. The Privy Council while disagreeing with the Federal Court of Malaysia's view that evidence should have been brought from a medical witness of the highest

professional standing or that the evidence presented should have been supported by references to the writing of distinguished medical men, said, 'the test is the standard of the ordinary competent practitioner exercising ordinary professional skill, and on this the evidence was all one way .

On the other hand, in the Nigerian case of Kanu Okoro Ajegbu v. Dr.E.S. Etuk[26], the deceased was admitted into the Onitsha Genera! Hospital on 16th of August 1961 by the defendant doctor who diagnosed a niptured appendix. He treated the deceased with antibiotics to localize the infection and perform an appendectomy on the 17th of August, (i.e. the next day). Only one incision was made but it had to be extended to expose the appendix properly. On the 20th of August, the deceased was given an enema because his stomach was slightly distended. As it did not work, the nurse who gave it reported this fact to the defendant who instructed that a little more enema be given to him and that if it failed, a flatus tube should be used. The second enema again proved ineffective. Upon the doctors further directives that a flatus tube be used if the second enema did not prove successful, flatus was then resorted to and a fllatus tube was accordingly inserted and all the enema and air were discharged. The deceased later died on the 21st of August 1961. There was some evidence that the death might have been due to delayed chloroform poisoning. However, no postmortem examination was conducted to establish the actual cause of death.

A dependant of the deceased sued the defendant under the Fatal Accident's Act 1961, claiming damages for the death, which the dependants attributed to the negligence of the defendant. The particulars of the negligence

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

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

On the question of neglect raised in ground two the court found that it was not true and in addition there was the fact that there were only two doctors attached to the General Hospital, which was far inadequate.

On the allegation of poisoning through over-dosed chloroform the court found that even though there was medical evidence that the symptoms before death were consistent with delayed chloroform poisoning, the witness was not categorical on this because no postmortem examination was conducted in order to ascertain whether or not it was the actual cause of death. It was finally decided that the plaintiff had failed to prove his allegations, where upon, his claims failed as well.

It would appear that on factual grounds there would have been a strong case against the doctor relating to poisoning by overdose chloroform had

postmortem examination been conducted to ascertain the cause of death. The decision of the court in this case was proper because, it is the general principle of law that he who alleges, must adduce cogent evidence to prove. It was, therefore, the responsibility of the plaintiff to order for postmortem, to garner evidence for postmortem, to garner evidence for his case. With due respect to Saleh Mohammed, contrary to his view that the doctor ought to have advised the plaintiff to submit the body of the deceased for posmortem[27], it is not and was not the responsibility of the doctor to facilitate the case of the plaintiff. It is thefore submitted that, in the event of any allegation of negligence leading to injuries or death, proper tests must be ordered to be conducted by the plaintiffs to categorically ascertain the causes of the injuries or death.

The duty of a dentist to exercise due care and skill in his treatment of his patients is the same as that of a surgeon or a physician[28]. However, leaving tooth in the jaw after an extraction and fracturing the jaw during an extraction are not themselves evidence of negligence against the dentist, but he will be liable if he did not notice the said dislocation or further dislocation in his subsequent examinations of the patient[29].

Nurses also owe a duty of care to persons they treat professionally. A nurse would be liable if she negligently carries out the following acts:

(a) Administer an overdose of dangerous drug owning to a mistake in reading the amount ordered by the doctor.

(b) Scalding a patient with boiling water[30]. It should be noted that from the result of our questionnaire, patients especially pregnant women during ante natal clinic

sessions and during delivery have been unnecessarily scalded by nurses and ward servants. It is submitted that hospital management should organize ,hort training courses in law of torts, to educate medical practitioners on their legal responsibilities towards their patients. This will minimize malpractice suits and its attendant huge financial costs and the redeem the image of the health care providers.

2.2.2.3. **Improper Administration of Drugs**

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

In addition to those deriving from drug reactions, other liability situations in the use of drugs may involve choice of the wrong drug for the patient's condition, over dosage, or infections that follow injections and results from the use of unsterilised equipments, or solutions[32]. Below are summaries of cases of negligence involving the administration of drugs. In Whitefield v. Daniel Construction Co[33], the plaintiff sustained a minor laceration of scalp when in red on the job. He was sent to his employer's physician, who, after suturing the

laceration gave to the patient capsules containing $1^{1}/_{2}$ grains pentobarbital to be taken for pain. Pentobarbital is a barbiturate and a sedative. The patient was given no instructions as to use of the drug. The fact that it might put him to sleep or affect his faculties and that the number of capsules should be limited, were not mentioned to him. When driving home, the patient drove his struck off the road into a field, later he drove his truck off the road again and was killed. It was held that the death was a result of the patient taking the drug improperly prescribed by the physician and that the employer was liable for death benefits under workmen's compensation.

In the Nigerian Supreme Court decision of University of Nigeria Teaching Hospital Management Board and others v. Hope Nnoli[34], Hope Nnoli, working with the U.N.T.H, was the only qualified chemist in the compounding unit for her employer at all times material to this case. An unqualified pupil pharmacist named Mr. Nwuzor, who was then undergoing his internship with the hospital, was posted to her unit. Being on internship, Mr. Nwuzor was not supposed to compound medicine on his own without supervision. On 20th February 89, Mr. Nwuzor allegedly compounded chloroquine syrup, which caused the death of children aged between one, and four years who took it. Postmortem examination confirmed the cause of death. Analysis of the syrup by the central Drug Control Unit of the Federal Ministry of Health revealed that the said chloroquine syrup contained about eight times more chloroquine phosphate than a norma! dose. Such overdose, it was deciphered, is dangerous and liable to result in deaths of children between one and four year. Sequel to the deaths of the children, there

was a public outcry and the Management Board of Teaching Hospital conduced an investigation to ascertain the person or persons involved or responsible for the overdose. And it was accordingly Nnoli and Mr. Nwuzor who were found liable in negligence.

The above two examples, as pitiful as they are, remind us that extra-care and caution must be taken or encouraged by employers to be taken by medical professionals where they are discharging their responsibilities. It is therefor recommended that where an employee performs his duty recklessly, leading to medical malpractice, apart from paying damages, the employers should also ensure that appropriate disciplinary measures are taken against them. From the findings in our questionnaire, the issue of drug mal-administration is a common phenomenon amongst medical practitioners in Nigeria. It is also recommended that, in order to curb such a malpractice, professional bodies should have an input with a view to taking disciplinary actions against professionals who exhibit or are found to have exhibited such unpardonable levels of indiscipline and negligence.

2.2.2.4 **X-Ray Injuries:**

The use of x-ray has for longtime been a cause of multiple professional liability claims. Radiologists are more likely to be involved in this kind of personal injury actions than are many other medical specialist. Most of the complaints here involve therapeutic uses of x-ray, allegedly resulting in burns, fibrosis of internal organs, sterility or prenatal injuries. There are also numerous cases that involve a claim of insufficient diagnosis, the physician failed to use the x-ray as a

diagnostic aid and thus, failed to learn of a fracture or other condition[35]. The most typical of the cases here, is Farrara v. Gallucio[36]. The plaintiff, suffering from bursitis in her right shoulder, received series of x-ray treatments from the defendant radiologists. During the treatment, she experienced nausea. Subsequent to the seventh treatment, her shoulder began to itch, the skin turned red, blisters formed and then ruptured and the skin peeled, leaving the raw flesh of the shoulder exposed. Scabs formed and lasted for several months. One scab lasted for several years. Her condition was diagnosed as chronic radic dermatitis caused by x-ray therapy. A judgment of £25,000 against the physian was affirmed. Of this verdict, $15,000 was for mental anguish that the plaintiff suffered as a result of her fear of developing cancer from the burns ("Cancerphobia"), a dermatologist having allegedly told her that such cancer might develop.

It has been found from interview with medical practitioners that injuries arising from x-ray therapy are common in Nigeria, but because of ignorance and illiteracy, victims hardly notice the injuries and even when they do they hardly have the means to consult specialists to ascertain the cause. Awareness programmes are therefore recommended in order to educate potential patients of x-ray therapy on their rights.

2.2.2.5 **Anaesthesia**

The administration of anesthesia is one of the sources of litigation in medical civil negligence. It could be claimed that a particular anesthetic agent was given in excessive dosages, either because of the patience low tolerance or

because of a failure to recognize complications demanding reduction of the dose. Disregard of sensitivity to the anesthetic is often claimed as a source of damages. There are very many cases alleging complete paralysis following the use of a spinal anesthetic. Also, errors in the use of anesthetic gas machines have been involved in cases of asphyxiation. The breaking of the needle used to inject anesthetic has given rise to claims, as have injuries to the teeth and mouth following inhalation of anaesthetics[37].

Inherent in the anesthetic situation is the dreaded "cardiac arrest", where in the medical practitioners are confronted with the tragic dilemma of the so-called 4 to 7 minute "eternity," within which to attempt to resuscitate the patient[3]. If such attempts bring back the body but not the mind (i.e. permanent brain damage from cerebral hypoxia and/or anoxia), the expense involved in keeping and in maintaining such a person will be too enormous to bear. In a situation of this kind, and malpractice suit against a Medical Practitioner may run into very large figures[39].

A typical American case involving negligence in the use of anesthetic is Weinstein v. Prostkoff[40]. In the case, an action was brought by the administrator of the estate of the deceased to recover damages from the attending physician, the nurse anesthetist, and the hospital for death allegedly caused by negligence involving anesthesia during the delivery of the deceased's child. A verdict in the amount of $60000 was returned against the physician. The jury found that the nurse and the Hospital were not negligent. The decision in favour of the nurse and the hospital were reversed on appeal on the grounds that since the physician

failed to properly supervise the administration of the anesthesia, the decision absolving the nurse, who administered the anesthetic and the hospital employer of the nurse, were contradictory. This is good law because it is a fundamental principle of law of torts that one should not be allowed to benefit from his own wrongs.

Meanwhile in Nigeria there is the case of Kanu Okoro Ajegbu v. Dr. E.S. Etuk[41]. In this case, the deceased was admitted into the Onitsha General Hospital on 16th August 1961, with a diagnosis of ruptured acute appendicitis by the defendant doctor. He developed complications and died. The dependant of the deceased sued the defendant for negligence, alleging that the operation lasted three and half hours instead of 45 minutes and that there were two incisions instead of one. They also alleged that the defendant did not attend to the deceased because he did not come in as his private patient. It was alleged that there was an overdose of chloroform or anesthesia and this was established as a matter of fact. The court, however, acquitted the defendant on procedural grounds in the sense that postmortem examination had not been conducted to establish the cause of death. This decision seems to have been properly grounded because anesthetic death are physiological and the evidence disappears with death. At postmortem if death is caused by anesthesia, the odour of the anesthetic agents may be unmistakable[42].

2.2.2.6 **Surgery**

Surgery is a very difficult area of medical practice. It is undoubtedly the one single greatest source of professional liability suits. Surgical problems may

arise, among other ways, from the diagnosis of the referring physician or from the diagnosis of the surgeon. Generally, the surgeon is not expected to make an independent diagnosis. The requirement of ordinary care is fulfilled by his accepting the diagnosis of the referring physician. Assuming that the latter is a physician of good reputation and that there is nothing apparent about the patient's condition to suggest the likelihood of an erroneous diagnosis. Surgical mishaps may arise from the inadvertent cutting or tearing of tissues. However, such accidents do not necessarily indicate negligence on the part of the surge since the cutting or tearing may have been the result of anatomic distortions, either natural or brought about by disease or prior surgery. The medical practitioner in the exercise of due care will not necessarily be aware of such anatomic distortions in time to avoid inadvertent cutting sometimes, the damage resulting from such cutting or tearing is recognizable at once and at other times, it may not appear for a period of years[44].

Leaving foreign bodies in the patient, such as sponges, gauze, needles, instruments and swabs, gives rise to the a considerable number of claims. In such cases, the courts apply the doctrine of Res Ipsa Loquitur, under which negligence can be proved by circumstantial evidence. Thus, in Hoking v. Bell[45] a surgeon was held liable in negligence for leaving a ward of surgical gauze in a patient's body after an operation and for leaving a portion of drainage tube in the site of an operation. Also, in Mahon v. Osborne[46] swabs were left in a patient after operation, the court allowed for the application of the doctrine of Res Ipsa Loquitur and the defendants were held liable. In Maynard v. West Midland

Regional Health Authority two consultants believed that the plaintiff was suffering from pulmonary tuberculosis but also considered the possibility that she might have Hodgkins disease. She was in fact suffering from tuberculosis. Tests were carried out, but it was decided to operate before the results of the test were known. The plaintiff claimed damage to the vocal chords as a result of the operation. It was held by the house of Lords that the defendants were not negligent, as they had conformed to a practice approved by a responsible body of medical opinion. Where there are conflicting practices (as in this case), negligence is not established by proving that the defendant has not flowed one practice.

From the above decision, it appears that the principle of liability based upon fault, is receding at this point. When it comes to professional liability, the corresponding terms fault and negligence no longer signify mere careless conduct; rather they are employed to signify failure to observe not the care generally observed by the average diligent man, but that level of care which, in line with good professional practice, is deemed necessary in order that exercise of the profession may be regarded, as diligent.

Surgical mishap is a common phenomenon of medical negligence in Nigeria, leading to numerous surgical deaths. Investigation from questionnaires has revealed that a wide range of problems, including poor or absent documentation, deficiencies in essential services, surgeons operating outside their specialty and the use of poorly trained and supervised locum are causes of surgical deaths. It is, therefore, recommended that hospital managements,

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should improve on the available surgical facilities, obtain modern surgical instruments, employ well trained staff and specialists and re-train them periodically, in order to enhance efficiency and minimized the rate of surgical mishaps.

2.2.2.7 **Blood Transfusion.**

Claims in negligence for medical liability in blood transfusion arise in several different ways. One type of such claims arises from the use of mismatched blood. This can be caused either by laboratory errors in cross-matching or by clerical errors whereby blood intended for one patient, is given to another. Administration of mismatched blood can produce a variety of injuries, including shock, serious kidney damage and even sudden death. Blood transfusions have also been responsible for serious infections being transmitted, such as, Acquired Immune Deficiency Syndrome (A.I.D.S), Veneral diseases, jaundice hepatitis, etc. In the United States of America, suits involving transfusions are move frequently filed against a hospital than a physician. Thus, in Necolayff v. Genesee Hospital[49], the plaintiff was recovering from a surgical operation. An intern and a nurse entered her room and told her that she was to have a blood transfusion from her daughter. Although she protested, informing them that she had no daughter, they nevertheless administered the transfusion. As a result she became seriously ill and temporarily insane. Actually, the transfusion had been intended for another patient. The court held the hospital responsible for the negligence of the intern and the nurse.

Another type of claims here, is related to use of mismatched blood. This is sometimes caused by laboratory errors. Thus, in Berg v. New York Society for Relief of the Ruptured and Crippled[50], the plaintiff, who had suffered from rheumatoid arthritis, entered the defendant hospital for a course of treatment that included the administration of 500ml of blood. Prior tc performance of the transfusion, a sample of the plaintiff's blood was sent to the hospital's laboratory for analysis. A technician who tested the sample, reported that her blood was Rh-positive. She was transfused with Rh-positive blood, but the transfusion war stopped when she started to develop an adverse reaction. A few months later she was discharged from the hospital, she became pregnant and was directed by her family physician to a laboratory for the purpose of determining her Rh factor. It was then discovered that she was Rh. Negative. She later gave birth to a stillborn foetus and was unable to have children. Suit was brought against the attendant physician and the hospital. The case against them however on the basis of the technician's negligence succeeded.

It appears that the courts are more willing in granting judgments against hospital to the exclusion of their employees, because the consequences of mal-administration of blood transfusions are grievious and therefore, attract huge sums by way of damages. It therefore, became necessary to hold the hospital liable because they are solvent enough to settle the gigantic claims.

With respect to Nigeria, it would appear from the instance below that, just like in the United States of America, the responsibility for mal-administration blood transfusion, is always shouldered by the hospital management. Thus, in

the instant case, one Mr. Ude Oche, engaged the services of a solicitor who wrote in April 1998 to the Ahmadu Bello University Teaching Hospital Management, claiming a sum of N2.5 Million, being special and general damages, as a result of negligence and breach of duty in blood transfusion leading to the death of his wife on the 23rd of December, 1997.

He alleged that, following the doctors prescription for surgery, blood grouping and cross match was performed after undue delay. He expressed dismay over the apparent authority and arrogance of Mr. Andrew, the 400 level student of Laboratory technology who conducted the test, after a very considerable delay. After the test, Mr. Andrew came up with AB RH positive result. But Mr. Oche informed the staff that the correct blood group of his wife was O RH positive and not AB RH Positive. The Doctor, relying on the laboratory result transfused the AB RH positive to which the wife reacted badly. At this point, another laboratory staff was compelled to repeat the test, which confirmed O RH positive and not AB RH Positive. Although this correct group was eventually transfused, the wife never really got over the reaction until she passed away on the morning of 23rd December 1997.

In 1998, the A.B.U.T.H.'s solicitors entered into negotiation with the complainant's solicitors. A settlement out of court was reached in which the hospital paid a certain amount of money to the complainant and various disciplinary measures were meted against the hospital staff responsible for the injury[51].

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

2.2.2.6 **Abandonment**

Where medical practitioners abandon their patients, that is, neglect them in the course of treatment; they may be liable in negligence. Thus in the case of Barnett v. Charlsea And Kensington Hospital Management Committee[52,] a casualty officer of a hospital was held to have been negligent in refusing to see a patient who had presented himself at the casualty Department complaining of Vomiting but had referred him to his own doctor. The can was in fact suffering from Arsenical poisoning. Similarly in Dickson Igbokwe v. U.C.H. Board Management[53], the deceased was admitted to a 4th floor of the UCH. Where she gave birth in December 1958. She was suspected of being mentally deranged and was placed on sedatives. The following day, she was missing from her bed and was found dead on the ground 70 feet below. The husband sued the U.C.H. Board for neglect. The U.C.H. authority agreed that if someone had been assigned to look after her, the unfortunate event may not have happened. The plaintiffs action was upheld and a sum of two hundred and fifty pounds was awarded as damages to the woman's children. The husband was excluded from benefiting because he could not show evidence that he had done native marriage with the deceased.

2.3 Civil Liability of Quacks and Native Doctors.

A quack or a native doctor is one who is not qualified under the Medical and Dental Practitioners Act[54], to practise as a medical practitioner in Nigeria. Any unqualified or an unlicensed person, who undertakes medical treatment is required by law to exercise the same degree of skill, knowledge and diligence, as a person qualified to practise the profession is required to exercise. His guilt will not arise merely because he is unqualified or because he is not authorised to practise, but also if he falls short of the standard required of a qulified practitioner[55].

In the case of R.v. Chigbata Olise, the accused was indicted before the Warri - High Court on three count charges, viz; Manslaughter of one Justina Onwuzulike contrary to section 325 of the Criminal Code (C.C), Cap.4; being in possession of poisonous matter without lawful authority, contrary to section 59 of the Pharmacy Ordinance, Cap. 69, and giving injection of a drug into the skin of the said Justina Onwuzulike, the accused not being a qualified person to whom licence had been given for that purpose contrary to section 34 (1) of the medical Practitioners and Dental Ordinance, Cap. 130.

The facts of the case went thus: The deceased and her husband approached the accused on the 29th August 1959 and asked him if he could treat the deceased who had earlier complained of chest and heart problems. The accused agreed to treat the deceased for a fee of £9,17,3d; £6 which was paid in advance. After the husband had left the deceased with the accused, the latter attempted to give the deceased an injection at the back of her hand using a

hypodermic syringe and needle. When this was not possible, he gave her the injection in the shoulder area. The deceased died later that evening. When he was later asked by a councilor of that area whether he treated the deceased, he (accused) admitted giving her injection and said that he was a doctor. The report of the doctor who - did postmortem examination of the deceased showed that she died of acute poisoning from a drug injected into her body. When the house of the accused was searched, poisons in part III of the First Schedule of the Pharmacy Ordinance were found. The accused admitted that the poisons were found in his house but said they were put there by the relations of the deceased and denied giving the deceased any injection. He did not give any evidence that he was a licenced doctor under the Medical Practitioners and Dentist Ordinance or that he had any lawful authority to be in possession of the poisons. The court held that:-

(1) Since that accused had not shown that he had lawful authority to be in possession of the poisonous materials, he was guilty of being in possession of them for unlawful purpose,

(2) If a person without medical training takes on himself to sidminister medicine that has dangerous effect and such medicine destroys the life of another person, he is guilty of manslaughter and recklessness. The accused was accordingly convicted of all the two-counts charges.

In yet another case, that is R.V. Samuel Abengowe [56], the deceased was taken to the appellant for treatment. She was then suffering from sores on her back and breast, which had lasted for about three years. The appellant, an

unqualified doctor filled a syringe into the right buttock of the deceased and pumped the liquid into her. The deceased fainted immediately. A day after that, her husband found that her right leg and buttock were swollen and the buttocks were peeling, looking red. She died the next day. The incidence v. was not reported to the police until about three weeks thereafter. After conducting post-mortem examination, the doctor reported that the deceased had been suffering from syphilis for some years and according to him, this would render her susceptible to poison. He then removed some part of her liver and kidney and sent them to Government analyst, who examined them and made a report.

At the trial, the report of the Government analyst was rejected by the trial court as inadmissible. No reasons were given for their inadmissibility. Judgment was passed against the appellant. The Appellants appeal succeeded on the grounds that although it was obvious from the records that the accused was tried for manslaughter by negligence, it was not clear what particular form of negligence was relied on by the prosecution to disclose with certainty and precision and without inconsistency the particular form of negligence alleged. The prosecution therefore, failed on appeal for want of proof[57].

It would appear from court decisions that native doctors are placed on the same level with quacks with regards to negligence. A case in point, which illustrates this, is the case of R. v. Ezeoca[58]. In that case, the appellant, who was a native doctor, was charged in the Supreme Court of the them Abba Judicial Division with manslaughter. The prosecution's case was that the appellant gave the woman three injections at intervals of seven days for which he charged #35 a

time. Shortly after the last injection, the deceased became very ill. She died eight days later. The appellant asked her sister not to report the matter. After his arrest, he made the following statements, which he later denied in defence.

> I did give injection to one Owerri Aba woman in the year, 1943 as I was passing by the road. The woman was very sick. She asked me to inject her with my injection. She said she had tried many other injections. I did not agree at first but she compelled me. I warned her very seriously . still yet she said I would not be responsible for whatever might be the result. I told her that she would pay *H25.5,* when she got better, or leave paying anything if she did not recover. I did it by favour

In his defence at the trial, he denied injecting her as mentioned in his statement to the Police above and instead claimed that action was instituted against him by the family of the deceased out of revenge as a result of another matter unconnected with death of the deceased. An analyst report, which indicated that death was caused by loxaemia due to bismuth injection was accepted by the court. Then the court after coming to the conclusion that the prosecution's case had been substantially established convicted the defendant for the offence of manslaughter.

On appeal, it was held that there cannot be the slightest doubt that it had been established that the accused was guilty of criminal negligence and rightly convicted of manslaughter. His appeal was therefore, dismissed. In yet another case, R. v. Yaro Paki and another[59], the first accused was charged with manslaughter for operating on the tonsils of his patient who subsequently died. The second accused who was charged with aiding and abetting by holding the patient's head during the operation, was discharged and acquitted on the ground

that the operation on the tonsil's by the first accused was not itself an unlawful act like an operation to bring out abortion.

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51.Ref. A.B.U.T.H./PLG/62, Minutes of the meeting of Ethical Committee Held on 4/9/98 at the Conference Hall ABUTH, Kaduna to, deliberate on the Report submitted on the death of one Mrs. Ama Oche.

52. (1969) 1 Q.B. 528.

53.(1961) W.R.N.L.R. 173.

54. Cap. 221, Laws of the Federation of Nigeria,

1990.

55. See Unurah B.C. Op. Cit. at P. 122.

56.(1993)3. W.A.C.A. 85.

57. Sale Mohammed Op. Cit o. 94.

58.(1946) 2 WACA.56.

59.(1955) 2 N.L.R. 63.

CHAPTER THREE TRESPASS AND CRIMINAL LIABILITIES OF MEDICAL PRACTITIONERS. 3 1. INTRODUCTION.

This chapter shall consider the liability of medical practitioners in trespass arising from treatment without consent of the patient. This therefore, will re quiere a thorough analysis of consent and its scope for purposes of medical practice as well as some good analysis of battery and assault. The second part of this chapter, shall be concerned with the liability of medical practitioners in crime, arising not from deliberate intentional acts, but from gross negligence in the performance of their duties. And lastly, the third phase of the chapter shall examine the liability of hospitals or establishment for medical malpractice. 3.2 **Liability In Trespass**

Trespass in this area of the Law, refers to trespass to the parson, precisely battery and assault. Trespass to the person means; direct and forcible interference with the person of another, without consent, express or implied. At Common Law, any medical practitioner who treats or carries out any professional activity on a patient without his consent, express or implied, such an act can give rise to assault. Consent is therefore central to the idea of medical practice and the doctor-patient relationship and in determining the liability of medical practitioners in battery let us first of all discuss the concept of consent as it affects the practice of medicine.

3.2.1 **Consent To Treatment:**

Apart from malpractice, the other classical category of medical professional liability comprises cases where surgical or other treatment is applied without the consent of the patient. This is a violation of the basic principles, both of medical ethics and legal science, the validity of which is generally recognized in all legal systems. The physician has no right to examine or treat a patient without his consent. The consent that is in issue here is not the consent as a constitutive element for the conclusion of the contract with the medical practitioner, but consent as a condition precedent to and justification for the legality of the physician's intervention. This principle applies in Nigeria particular and in other countries in general with variations in its technical formulation. This rule is subject to the exception that in an emergency if it is impossible or impracticable to obtain the patient's consent or the consent of anyone authorized to assume such responsibility, in which case, the law implies consent[1]. In conformity therefore, with medico-legal ethics[2], the medical practitioner is under an obligation to treat without consent, especially when the patient's condition is such as to imperil his life. Although the physician has no right to take action by force or by misleading the patient.

The general rule prohibiting the performance of an operation without the consent of the patient extends to the performance of an operation different from that for which a consent was given, as well as to operations involving risks and results not contemplated[3]. The burden of proving want of consent is on the plaintiff[4]. In order to understand the nature of consent required to satisfy the

requirement of medico-legal ethics, it is necessary to consider the scope of the consent.

3.2.1.1. **Scope of the consent-informed consent-**

informed consent simply means that a patient who is matured and who is able to take decisions based on sound reasoning must be fully and sufficiently informed about the purpose, nature and the implications of the medical treament to be administered on him, including the risks involved, so that he may chose whether to go in for it or not. Therefore, what is needed, is not consent per say, but genuine and informed consent. Especially in the case of dangerous application of novel and incompletely tried methods of diagnosis or cure. Consent is no defense unless it is given to the precise treatment or operation or at least to acts of a substantially similar nature, with awareness of all the risks involved[5]. The extent of the medical practitioner's duty to inform and enlighten the patient regarding any possible harmful effects increases proportionately as the intervention, as viewed by a prudent patient, is less necessary nor urgent[6]. Thus, it is possible that in some cases the physician should also enlighten the patient regarding improbably risks, if an intervention is not necessary, or other less dangerous ways of treatment that exist. This applies particularly to aesthetic operations, where the physician must refuse his services even when the patient, not only consents to, but insists on a dangerous intervention not sufficiently justified by the patients interest[7].

Physicians frequently fail to make a full disclosure to patients concerning the proposed treatment or operation. Unless this is necessary in the interest of

the patient's health, half-truth or "soft answers", may negative the patient's consent[8]. This means that, a doctor may exercise therapeutic privilege if he thinks that revealing a particular risk would be adverse to the patient's health[9]. In Sidaway v. Board of Governors of the Bethlem Royal Hospital[10]. The plaintiff had pain in her neck, shoulder and arms. A neuron-surgeon examined her and recommended an operation. What the plaintiff was told is not clear, as the surgeon had died by the time of the trial. The operation carried out with a 1 % risk of damage to the spinal cord and a 1-2% risk of damage to nerve roots. The surgeon had apparently told the plaintiff about the risk of damage to the nerve roots but not of that to the spinal cord. The operation was carried out without negligence by the surgeon but the plaintiff was severely disabled as a resulted damage to her spinal cord. The House of Lords held that the surgeon had followed approved practice of neuro-surgeons in not disclosing the risk of damage to the spinal cord and was not negligent.

The majority of the House (Lord Scarman dissenting) was prepared to accept a modified version of Bolam test for the giving of information. The major modification was that, where the judge thought that where disclosure of a particular risk was obviously necessary but it was not medical practice to disclose, then following standard practice would not avoid liability. The example given was a 10% risk of a stroke. If medical practice was not to disclose of the risk, then a court would import this decision to the effect that, where the court considers that a particular piece of information was necessary, failure of the medical practitioner to disclose in exercise of therapeutic privilege will not be

accepted, even if his action is in line with current medical practice. This is especially so because the patient's right to know the risk involved in the treatment is based on self-determination. A doctor will therefore, only have a defence of therapeutic privilege if disclosure would have posed a serious threat of psychological detriment to the patient.

A surgeon, charged with a particular operation, is not also justified in departing from instructions and performing a different one, except in an unanticipated emergency, calling for an immediate decision to save life or preserve health 11. But in cases involving the discovery of an unforeseen serious condition during an operation which requires departure from the intended procedure or extension of treatment *or* operation the issue whether the surgeon has authority to proceed or whether or not is decided on several criteria, especially on whether an emergency existed or the extension was necessary [12].

Where a patient, before undergoing an operation specifically asks the surgeon about the risk involved then he is bound to disclose fully. Thus, in Smith v. Auckland Hospital Board 13, the patient before undergoing exploratory procedure, specifically asked one of the physicians concerned whether there was any risk? The physician did not answer the question directly but in effect reassured the patient, although some risk materialized and the patient lost his leg. Evidence from other physicians showed that, although they would not, In like circumstances volunteer information as to the risk to the patient, they would tell him of it if specifically asked. In the circumstances the Court of Appeal upheld the Jury's finding that it was negligent for the defendant physician not to have

where harm is caused he may be liable in negligence or both in trespass to the person and in negligence[16]. Generally, when the result of some treatment is poor patients' solicitors prefer to allege unauthorized treatment or surgery rather than attempt to prove negligence, which is more difficult.

3.2.1.1. **Requirement For A valid Consent:**

For an informed consent to be validly obtained, the following requirements must be complied with, that, the (1) person who gave the consent must have had the requisite capacity to do so, (2) the consent must have been given based on knowledge of what is to be done and the repercussions; (3) the need to obtain fresh consent where the need arises for an operation or treatment entirely different in nature from that which consent was originally obtained, and (4) there must not have been any fraud in obtaining the consent. (A) **Capacity To Consent**

Capacity to consent here means, the ability in law, to freely and voluntarily consent to a treatment or operation being carried out on a patient having disclosed the nature of the treatment or operation, the material and psychological consequences in terms of risks and the dangers involved. With regard to the capacity of a patient to consent, he must be or age. If he has not attained the age of majority, then such a valid consent can only be obtained from his parents or guardians or next- of- kin. There is no certainty as to what constitutes the age of majority in this regard. However, it would appear that if someone has attained the age of 18 years he may give a valid consent or if he has attained such an age

that it could be presumed that his mind and brains are developed enough to have a general understanding of matters and be able to take decisions on them[17].

If the operation or the treatment is to be conducted on a patient shoes age is below 18, and that operation is not for his own benefit or someone who related to him, his consent and that of his parent must be obtained and such consent must not be given where the operation is totally of no benefit at all to the patient[18]. Where the patient is of age and therefore, can give valid consent, then the consent of his parent alone is not a licence for the doctor to go ahead and start treating him or to withhold treatment on him 19. The patient must consent himself, except where the patient is incapable of consent because of unconsciousness or other defective state of mind; otherwise, the physician will be liable in assault and/or battery or negligence; as the case may be[20].

Where a patient is mentally deficient his ability to give a valid consent will depend on the degree or extent of his mental ailment, if the mental illness is such that could impair someone's ability of proper perception then the consent of his parent or guardian is necessary but if it is not up to that level he may then give his proper consent for admission and treatment in the mental hospital[21], the patient is married, then the other spouse may give consent on his o ner behalf, if his or her condition is such that he or she cannot himself or herself give a valid consent[22]. (B) **Knowledge As A Requirement For A valid Consent**

For consent to be valid, the patient must have been fully informed about the kind of treatment or operation to be perform, the risk involved, the benefit of

such a treatment or operation to him and the alternative opened to that kind of treatment. Consequently a general consent obtained from the plaintiff if not enough for this purpose. A general consent here means, a consent given for treatment or operation without an advance knowledge of the risk and dangers involved. This is at variance with the doctrine of informed consent and therefore, unacceptable in medico-legal ethics. The patient in this regard, has the option of instituting an action in the tort of battery or in negligence against the medical practitioner. If he elects to sue in battery, then the issue of proving negligence will be immaterial because battery is actionable per se, that is, without proof of damage. If prefers' an action in negligence, then he must prove it, by pleading successfully, the ingredients of negligence. Thus, in the American case of Bowers v. Talmage and Von storch[23], a nine year old boy, who was suffering from hallucinations was taken to the defendants neurologist who being in doubt whether the druids trouble was emotional or organic, recommended .1 artenogram, an exploratory process in which three percent of cases are known to result in serious injury. There was no emergency that would warrant the performance of the operation. The defendant did not explain the dangers of the treatment to the child's parents but they gave their consent anywhere. The plaintiff was paralysed as a result of the treatment. In an action, it was held that "unless a person who gives consent to an operation knows it dangers and th degree of danger his consent does not represent a choice and is ineffectual"

Unlike the American courts who appear to be in favour of the patients as far as the disclosure doctrine before consent is valid is concerned English courts

seem to operate in favour of the medical practitioners. Thus, in England if a doctor, in exercise of therapeutic privilege, is of the opinion that informing a patient of the risks and dangers involved in a treatment or operation will be detrimental to his health or psychology them unless that opinion of his is not in line with the generally accepted practice in the medical profession, he may not be liable unless the patient himself can prove that if he were properly informed, he would not have submitted himself to that treatment or operation. Thus in case of Hatcher v. Black[24], the plaintiff, a singer, suffered from a diseased thyroid gland. She them underwent a thyroidectomy after being assured by the surgeon that there was no risk to her voice. A nerve was no badly injured in the operation that the plaintiff's voice was damaged. The doctor knew there was slight risk to the plaintiff's voice but refused to inform her about it in order that she should not get worried. The doctor was held not negligent because his action did not fall short of the standard of a reasonably skilful surgeon. Nevertheless, the House of Lord[3], although maintaining the principles above has brought in, some slight modification. Thus, in Sidaway v. Board of Governors of Bethlem Royal Hospital[25]. The plaintiff, had pain in her neck, shoulder and arms. A neuro-surgeon examined her and recommended an operation. What the plaintiff was told is not clear, as the surgeon had died by the time of the trial. The operation carried with it a 1% risk of damage to the spinal cord and a 1-2% risk of damage to the nerve roots. The surgeon had apparently told the plaintiff about the risk of damage to the nerve roots but not that to the spinal cord. The operation was

carried out without negligence by the surgeon but the plaintiff was severely disabled as a result of damage to her spinal cord.

The House of Lords held that the surgeon had followed approved pratice of neuro-surgeons in not is closing the risk of damage to the spinal cord and was no negligent. The House of Lords, however, ruled that where the judge though that disclosure of a particular risk was obviously necessary but it was not medical practice to disclose, them following standard practice by a medical practitioner will not avoid liability. What this simply means is not whether or not, starnderd medical practice will avail a medical practitioner for withholding information before carrying out an operation or treatment, will depend on the discretion of the court. And this discretion is to be exercised, taking into consideration all the circumstances of the cases.

With respect to the position where the patient specifically asks questions, it is not clear. In Sidaway v. Board of Governors of Bethlem Hospital[26], Lord Bridge was of the view that there is a duty to answer as truthfully and as fully as the questioner requires. However, in BIyth v. Bloomsbury Health Authority[27], the Court of Appeal said that there was no duty to pass on all the information available to the hospital. The reply would be satisfactory if it confirmed to standard practice.

It is submitted that a reasonable man would hesitate to undertake hazardous treatment, and therefore, unless therapeutic reasons contra indicate[28], doctors should always make simple, quiet but honest disclosure commensurate with the risks in all cases and let the patients choose what risk or risks to run with

their bodies. Where for therapeutic reasons, it is medically and legally unethical to inform the patient of the risks or dangers involved in the treatment *or* operation, a responsible relative of the patient should be inform on the patients behalf and obtain his or her informed consent, before embarking on any treatment or operation. Beside, informing the patient or a close and responsible relation of the risks or hazards involved in an operation *or* treatment it should always be insisted that a consent in writing in which the patient or someone on his or her behalf acknowledges this explanation. This procedure is in place in some hospitals in Nigeria especially, the Ahmadu Bello University Teaching Hospital, Zaria.

(C) **The Need to Obtain Fresh Consent on An Issue Entirely Different from the One Earlier Consented To.**

The question to be asked and answered here, is what happens, if in the course of an authorised treatment, a medical practitioner encounters a condition, constituting a threat to the patient's life for which the patient had consented to treatment or operation? The general principle of English Law and probably, Nigerian Law in this regard is that, if a patient's consent is given in respect to a treatment and in the course of the treatment a new case requiring treatment is found, the doctor should seek for a fresh consent from the patient or from someone on the patient's behalf, before embarking on the treatment of the new issue. In a case, Mohr v. Williams29, a doctor was employed to perform an operation on the plaintiff's right ear but after anaesthetizing her and examining her and finding that the condition was not serious in the right ear as he

supposed, but found a more serious condition in the left ear went ahead to operate. He was held liable in battery despite the fact that the operation was successful, and skilfully performed since it was not in emergency situation. This implies that at Common Law, and as well as under Nigerian Law, the right of a physician to extend an operation beyond that authorized by the patient, is limited to emergencies calling for immediate action. An emergency has been defined as a medical situation such as to render immediate treatment advisable either to save life or to safeguard health[30]. Therefore, if in the course of an authorized treatment, a doctor encounters a condition constituting a threat to the patients life he may take such steps as may be indicated by good medical practice to correct the condition and remove the treat[31]. The courts are even giving a more liberal interpretation to the work "emergency" in situations where a medical practitioner or a surgeon followed good medical practice in extending an operation beyond that originally authorized, even though the additional procedure could not properly be characterized as life saving[32]. This position of the law is good in the sense that there could arise a situation where in the course an operation a surgeon comes across a problem which needs to be tackled immediately and neither is the patient in a conscious state to consent to the new situation nor are the relatives close by, to be contacted for their consent. Without the above exception, the duty of the doctor may be seriously interrupted to the detriment of the patient's health and life. That exception to the general principle of informed consent, is highly commended.

It should noted that, the Common Law rule was developed before the discovery of anesthesia, when the patient, if conscious could be called upon during the operation to consent to any medically advisable extension of the operation[33]. Because of this, modern progressive courts are departing from the rigidity of the Common Law. They express the more enlightened view that the instances in which a surgeon may extend an operation without the express consent of the patient are not confined to emergencies. Under this view, the surgeon is authorized to extend the operation to any abnormal condition discovered during the operation when this is advisable for the welfare of the patient and follows the approved practice of surgeons' generally[34]. This position is good in the sense that it will encourage self-reliant surgeons to whom patients may safely entrust their bodies and not men who may be tempted to practice defensive medicine or who may be afraid to perform their duties because of a law suit. Thus in the case of Barnett v. Barchrach[35], the patient complained of pain in her lower abdomen, which the surgeon diagnosed as tubal pregnancy. However, when he operated, he found that the patient had a double uterus and a normal pregnancy but a very acute appendicitis. He concluded that the latter condition was responsible for her pain and removed her appendix. The patient had an uneventful recovery and subsequently delivered a normal child. The patient's husband refused to pay the surgeon's fee for the reason that the appendectomy was unauthorized.

> The Court queried: "What was the surgeon to do? Should he have left her on the operating table, her abdomen exposed, and gone in search of her husband to obtain express authority to remove the appendix? Should he

have enclosed the incision on the inflamed appendix and subjected the

> patient, pregnant as she was, to a general spread of poison in her system, or to the alternative danger and shock of a second independent operation to remove the appendix? Or should he have done what his professional judgment dictated...?

Here the judgment for the surgeon was affirmed on the grounds that the surgeon had operated within the scope of the consent given him by the patient. Secondly, the surgeon removed what he believed to be the cause of the patient's pain, which was the essential reason for which the surgeon was engaged.

It is, therefore, submitted that where the need for extension of operation arises even where there is no emergency, and it is totally impossible and impracticable to obtain a fresh consent to deal with the fresh issue, the surgeon should be allowed to dispense with the need for a fresh consent and goes ahead to deal with the matter, provided the effect will be to achieve the purpose for which the surgeon was engaged. Here, the new operation should be located within the previous consent. This will be advantageous to the health and safety of the patient and will also protect the medical practitioner from financial and other material losses, arising from unscrupulous patients or their wardens. (D) **Consent Must Not Be Tainted with Fraud.**

Fraud here simple means intentional misrepresentation, that is deceit. A medical practitioner is under a duty to disclose to the patient the true consequences, that is, the risks and dangers, involved, whenever surgical, therapeutic, or diagnostic procedures and treatment, to be embarked upon, include more than the hazards that the patient might normally expect, A physician should not misrepresent facts on a particular operation or treatment to his patient or his guardian in order to get their consent. He should try as much

has he can, to explain to them in detail all the issue involved in the operation and their consequences. Thus, the doctor should not, for instance, under the pretext of treating a woman for one illness, perform an operation on her to cause abortion[36]. Any fraud on the part of a medical practitioner in obtaining consent, renders the informed consent null and void, and the practitioner may be liable for an action in assault, battery or negligence.

3.2.2. **Liability of Medical Practitioners In Assault And Battery.**

3.2.2.1 **Assault**

Assault according to Winfield and Jolowicz, "is an act of the defendant which causes in the plaintiff reasonable apprehension of the infliction of battery on him by the defendant"[37]. In other words, assault is the act of the defendant which produces in the plaintiff, a reasonable expectation of immediate unlawful bodily injury by force. In popular parlance or language, assault, covers both assault in the strict sense as described above and also battery, which is the actual application of force. Even in the Nigerian jurisprudence, it is increasingly common to use the term assault to cover both situations. We shall, however, only examine assault in the strict sense.

Assault unlike battery, does not require any bodily contact, because the gist of the tort of assault is conduct which threatens immediate force. In the majority of cases, battery comes immediately after assault by a very short interval. To throw an object at a person is assault, which the object is still in the air, but if the object strikes him, there is battery. Here, the defendant commits both assault and battery. It is, however, possible to commit battery without

assault, for example, where the plaintiff unexpectedly receives a blow from behind.

The essence of the tort of assault is threat of immediate force, hence so long as the plaintiff reasonably expects immediate force, the defendant's ability to apply it, is irrelevant. Thus, to point an unloaded gun at someone constitutes an assault, provided that the person did not know the gun to be unloaded: R. v. St. George[38]. This position of the law is on the, assault involves apprehension of fear of immediate bodily injury to self, which is exactly what happens when a fire arm is pointed at the plaintiff by an aggressor.

For an action to lie in battery, there must be an intention to produce the apprehension of bodily harm. Therefore, once it is proven that the defendant intended to cause reasonable and immediate apprehension of battery to the plaintiff, he will be liable in assault even if he was intercepted by a third party before he could reach the plaintiff. Thus, in Stephens v. Myers[39], the plaintiff was acting as Chairman at a Parish meeting and sat at the head of a table, at which table the defendant also sat, being six or seven persons between him and the plaintiff. The defendant, having in the course of some angry discussion, wiich took place, being very vociferous and interrupted the proceedings of the meeting; a motion was made that he should be turned out, which was carried out by a very large majority. Upon this, the defendant said he would rather pull the chairman out of the chair, that to be turned out of the room. And immediately advanced with his fist clenched towards the chairman but was stopped by a church warden

who sat next but one to the Chairman. The court held the defendant liable for assault.

Mere words do not constitute assault no matter how frightful they are, but they may be relevant in determining whether a particular act constitutes assault or not. Secondly, those words might even negative a threat. Thus in Tuberville v. Savage[40], a man laid his hand menacingly on his sword, but at the same said, "if it were not assize time, I would not take such language from you." It was held that this was not an assault because it was assize time and there v. as no apprehension of violence. In Read v. Cocker[41] the defendant was liable for assault, when his menaces were accompanied by threats to break the plaintiff's neck if he did not get out.

In assault, the test of apprehension of fear is objective and not subjectives The act of the defendant must have been such that a reasonable man might fear that violence was about to be inflicted upon him. Therefore, a man too courageous to be frightened is nonetheless entitled to recover in assault, even if he was not afraid of the act of the defendant. Conversely, a man of extremely low courage cannot be entitled to redress, because he had exaggerated fears of contact. Thus, the act should be that which a man of ordinary courage would have been afraid, to warrant an action in assault. Assault is also a crime. If a criminal court awards compensation to the complainant, which he accepts then he may not bring a civil action for damages[42].

Consent is central to the idea of medical treatment and to the doctor patient relationship. There is a general principle that a person cannot complain

of that which he has consented to. A doctor, who treats without the consent of the patient, may be guilty of assault on the patient. The patient may give express consent, for example, by signing consent form for a surgical operation, or there may be an implied consent, for example, by holding out an arm for an injection[43]. It should be noted that besides proving to the satisfaction of the court that the treatment or operation was carried out by the physician without rela' consent or informed consent of the patient, the burden is also on the patient plaintiff to prove all other requirements of the tort of assault which we have discussed above. In fact, he must prove all of them.

3.2.2.2. **Battery:**

Winfield and Jolowicz described battery as "the intentional and direct application of force to another person"[44]. The act must be a direct one. Thus, it is not battery to set a broken chair for someone to set on it or to dig a hole for him to fall inside. Secondly, the act must be intentional. Thus, mere negligence or even recklessness resulting in a battery is not actionable in trespass, although, it may give rise to a cause of action in negligence. Intention, however, needs not exist at the commencement ofl the act of battery; it may be formed while the act is still continuing. Thus, in Fagan v. Commissioner of Mtropolitant Police[45], he defendant accidentally parked his car on a constable's foot. He deliber ately delayed to get off when he was told to do so. He was held to be guilty of battery because of his latter intention

Thirdly, there must he physical conlacl hotween the plaintiff and the (defendant. It must not necessarily be bodily contact. It is enough that the

defendant directly brings some material object into contact with the plaintifrf[46]. Thus, it is battery to throw stones at the plaintiff, to throw water on him, to spit in his face, to remove a chair on which he is about to sit, or to inject him or operate on him, without his consent.

Life, however, will come to a standstill or halt, if all bodily contacts were to give rise to an action in battery. Because of this, the courts in the past struggle to distinguish battery from legally inoffensive conducts. In Cole v. Turner[47], Holt C.J. described battery as, "the least touching of another in anger". This definition of battery is too narrow because anger is not a requirement for this tort. "The mere touching of another without consent, and in circumstances in which he or she might take umbrage"[48] is sufficient cause to sue, whether it be one in anger or happiness. For example, stealing a kiss from a pretty lady with dancing breasts, will amount to battery even though the kiss on the damsel might be done merely to pay tribute to her succulent beauty. In fact, the basis of liability in battery is the intentional conduct of the defendant and not his motive. It suffices to show that his act was direct and wilful.

It should be noted that not all-physical bodily contact will give rise to action in battery. For example, holding someone by the hand in effecting a lawful arrest or to prevent a crime is not actionable. Similarly, "Contact conforming with accepted usages of daily life[49]. Thus, to push a person in a crowded market place or sports stadium will not constitute battery, though it may be actionable if the defendant uses violence to force his way through in a "rude and inordinate manner .

Battery is actionable per se, that is to say, without proof of real damage. So, where a person does not suffer real damage only nominal damages canbe recovered.

Consent is a defence in battery. However, in the case of Nash v. Sheen[51], the plaintiff went to the defendant, a ladies' hairdresser for a permanent wave. The defendant applied a tonerinse, which caused a scalp rash, which spread all over the plaintiff's body. The plaintiff claimed damages for battery. The defendant argued that she had consented to the treatment. It was held that the plaintiff succeeded; She had consented to having her hair styled, but that consent did not extend to the application of tenerinse.

Under English Common Law, as well as Nigerian Law, unauthorized medical treatment usually can give rise to a cause of action in battery. It is up to the plaintiff to plead and prove other elements that make up the tort of batty. Battery actions, protect personal integrity and guard against treatment without consent.

Consent as has earlier been said in this chapter is central to the idea of medical treatment and to the doctor-patient relationship. There is a general principle that a person cannot complain of that which he has consented to. A doctor who treats without consent may be guilty of battery on the patient. The patient may give express consent, for example, by signing a consent form for surgical operation or there may be an implied consent, for example, by holding out an arm for an injection[52]. The patient's consent must be real. Once the patient has been informed in broad terms of the nature of the intended procedure

and gives consent, then that consent is real. In Chartterton v. Gerson[53], the plaintiff suffered a trapped nerve after a hernia treatment. She consulted the defendant specialist who performed an operation to free the trapped nerve. As a result of the operation, the plaintiff lost all feelings in her leg. She sued the defendant in battery on the grounds that she had not truly consented to the operation, as its effect had not been properly explained to her. The claim failed A battery action could only succeed where the consent was not real. As the defendant had explained the nature of the operation in general terms, her consent was real for the purposes of battery.

In the case of Mohr. V. Williams[54], where a doctor was employed to perform an operation on the plaintiff's right ear but after anaesthetizing her and examining her and finding that the condition was not serious in the right ear as he supposed, but found a more serious condition in the left ear and sent ahead operate, he was held liable in battery despite the fact that the operation was successfully and skilfully performed since it was not in an emergency situation

It should be noted that, any alleged failure by the doctor to disclose risks about the treatment, which might have enabled the patient to give an informed consent, does not invalidate the consent. Therefore, no action can be brought in battery with regard to this situation. An action here can only lie in negligence.

Where a patient is unconscious and therefore, incapable of giving a consent the doctor will be entitled to give treatment on the basis of necessity. In F. v. West Berkshire Health Authority [55], the test for whether treatment is necessary; is whether it is in the best interest of the patient. What is in the best

interest of the patient will be judged by the standards of a responsible body of medical opinion. The decision would appear to give the medical profession considerable latitude in deciding what is necessary. Nevertheless, even in an emergency situation, if the patient is conscious and capable of giving his consent, then the doctor must observe his wishes or be liable in battery. but if the patient is unconscious and the doctor is unaware of the objection nen provided the best interest of the patient test is satisfied, no liability at aches. Consequently, if the doctor is aware of the objection, then it would appeal that the doctor may be liable if he goes ahead with the treatment, it *or* operation.

It is submitted that when patients allege battery they almost invariable prefer civil to criminal proceedings as their desire is to make all possible profit from what has been, in the vast majority of cases, nothing more than an made in all good faith, but occasionally the medical practitioner finds himself. in a court room. It is, therefore, recommended that Nigerian Law should adopt the principle in the case of F. v. West Berkshire Health Authority[56], the will give the medical profession considerable latitude in deciding what is necessary and therefore reduce malpractice suits. 3.3 **Criminal Liability of Medical Practitioners**

The criminal negligence of medical professionals here, arises from gross recklessness and not a deliberate or intentional act. Criminal negligence consists of complete recklessness or disregard for a person the medical practitioner owes a duty of care to. This amounts to an offence against the state punishable in criminal courts. Allegations of criminal negligence against doctors

are very uncommon in Nigeria because of lack of education, ignorance, poverty and religious beliefs. One, therefore, has to go back to many ears to find examples. The basis of criminal negligence of medical practitioners was aptly put by Lord Hewart in R. v. Bateman[57], as follows:

> In explaining to injuries the test which they should apply to determine whether the negligence, in the particular case amounted or did not amount to a crime the judges have used many epithets, such as 'culpable', 'criminal', 'gross', 'wicked', 'clear'.' complete'. But whatever epithet be used and whether an epithet be used or not in order to establish criminal liability the facts be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the state and conduct, deserving punishment[58].

In the same case, R. v. Bateman59, Lord Hewartt L.C.J, also said that "A doctor is not criminally responsible for a patient's death beyond a mere matter of compensation and shows disregard for life and safety as to amount to crime against the State". Equally, the Privy Council in the Nigerian Case of John Oni Akerele v. The State[60], stated that,".... It must be remembered that the degree of negligence required is that it should be gross and that neither a jury not a court can transform negligence of a lesser degree into gross negligence by giving it that appellation". These were all pronouncements on the medical profession. But in my opinion the underlying principle is the same. That is, that for a medical practitioner to be held liable in crime for his negligence the plaintiff must in addition to proving other requirements of negligence, also satisfy the court that the negligence or incompetence of the doctor was gross and went beyond the mere issue of compensation and showed such disregard for life and safety of others to amount to a crime against the state and, therefore, punishable. this

forms the basis of criminal liability of medical practitioners for professional negligence at Common Law.

In Nigeria, however, apart from the established Common Law position, the penal laws, that is the penal code and the criminal code, applicable in the North and the South respectively, also provide for criminal liability of medicine

practitioners for their professional negligence. For instance, section 220(b) of the Pena; Code[61], provides that, "Whoever causes the death by doing an act wi h the knowledge that he is likely by such act to course death, commits the offence of culpable Homicide." The medical practitioner's action here, will amount to gross negligence and he may be convicted for manslaughter. An equivalent provision is to be found under section 303 of the Criminal Code62, applicable in Southern Nigeria. It provides that:

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

According to the above provision, it may be said that apart from liability imposed for omission to perform treatment or operation, one can still be held liable in criminal negligence where he did not use reasonable care and skill in the course of his treatment or operation if his failure to do so amounts to gross negligence of a wanton disregard to human life or safety of others. Thus, in the Nigerian case of Akerele v. R.63, the accused, a medical practitioner administered injection of drug call Sabita which he had prepared himself, to about fifty-seven children as a

cure for yaws during his tour of the then Owerri Province in 1940. The drug requires the greatest care because an overdose of it will cause a disease called Somatitis which may be followed by distressing symptom in the mouth and finally leading to someone's death. After administering the injection on the children ten of them died. An action was then brought against the doctor in respect of one of the children that died, for manslaughter. The grounds of the action were that (a) the prepared drugs were too strong (b) he administered an over dose of it to the deceased and that this amounted to gross negligence. The High Court accepted these contentions and found the accused guilty of murder and sentenced him to three years imprisonment. On Appeal to the West African Court of Appeal the decision of the trial Court was affirmed only that the sentence of three years imprisonment was substituted with fine of £500.

On further Appeal to the Privy council, it was held allowing his appeal

i) that there was no evidence to show how strong the Sabita was; ii) that in a charge of negligence -

a) the prosecution must prove the particulars of negligence, i.e. the act or omission amounting to the negligence.

b) the probable and not the actual result is what matters;

iii) that the evidence that some other children died as a result of their being injected with the same Sabita preparation is receivable to destroy any special defence by the accused that the drug called Sabita, could not cause death.

The claim in this case was therefore, defeated on technical ground for failure by the prosecution to prove the particulars of the alleged gross negligence of the defendant doctor. If they had done so it appears their case would not have failed. It was on a similar ground that the claim of the prosecution's case in R. v. Bateman failed.

It would appear from the provisions of the Penal Code and the Criminal Code that, one could upon proof of criminal negligence against him be convicted of a lesser offence, which is not as heavy as manslaughter; that offence may just amount to a misdemeanour only. This could be deduced from the provisions of Section 220(c), which provides that, "whoever causes death by a rash or negligent act commits the offence of culpable homicide". In an attempt to explain the import of this section, the draftsmen said:

> There is no intention on the part of the accused to cause death and no knowledge that the act done in all probability will cause death. A ras act is done overhasty and without fore though. Committing a rash act is criminal because an accused, knowing the act to be dangerous and that he may cause injury, nevertheless has done it[64].

Here, the defendant might have acted in all honesty in the performance of his work with no iota of imagination that what he was doing may cause injury or ham, but unfortunately, injury ensued. Here, his action will be compared to that of an ordinary competent medical practitioner to see if he measured up to that standard. If the standard exhibited by him falls bellow that of an ordinary competent medical practitioner then even though he acted with the greatest care and honesty, he may still be criminally liable in negligence. But even then his action is not the same with that of the doctor who abandons completely a

seriously sick patient. Therefore, even though both of them are guilty of negligence, their punishment may not be the same under the law since the degrees of their criminal negligence differ.

It is not also in doubt from section 34(1)(e) of the Criminal Code th at a lesser offence could arise from some kind of criminal negligence. it p ovides that:

> Any person who in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any person given medical or surgical treatment to any person whom he has undertaken to treat, is guilty of misdemeanour, and is liable to imprisonment for one year.

This clearly shows that a negligent act committed by a doctor in this kind of circumstance will only amount to a misdemeanour and manslaughter.

In the East Africa case of Dabholka v. the King[65], the accused who was a doctor, was charged with giving surgical treatment negligently and in a manner likely to endanger life or to cause harm contrary to section 222 of the Tanganyika (now Tanzania) Penal Code which is similar to section 343(1)(e) cited above. He was convicted and he appealed to the Privy Council contending that the prosecution must prove gross negligence in order to succeed. Their Lordship however dismissed his appeal on the ground that although the negligence which amounts to an offence must be of a higher degree than the negligence which only results in the payment of compensation it is not of a high degree as that which is necessary to give rise to the offence of manslaughter. The principle in this case is no doubt applicable also to the Nigeria situation.

It is, however, doubtful, if a charge of murder can be instituted against a negligent medical practitioner, but where the treatment or operation embarked upon by the doctor is itself illegal, such as committing an illegal abortion,and death is thereby caused, it is submitted that the doctor should be charged with murder. Again, a doctor who with an alleged consent of the patient or out of pity terminates his life, may be guilty of murder[66], it should be noted that liability for medical mishap is not limited to the medical practitioners who actually carry out the treatment, but may extend to the hospitals establishments that employ them.

3.3. Liability of Hospital Management.

The liability of hospital management in this regard is vicarious. Actually liability of hospitals for faults of its medical and nursing staff presents particular interest. Such liability is now recognized in all laws. It constitutes in principle, contractual liability and presents no deviation from usual principle.

In determining the group of persons for whom a hospital may be vicariously liable, emphasis is placed on the organizational test. Thus, the liability of a hospital is recognized to day for the negligence of employed physicians, nurses, resident medical officer, house surgeons, radiographers and even part-time anesthetists working either under contract for services or under contract of service in general. This development underlines the role and importance of vicarious liability in the field of medical practice. Since most of our medical practitioners are resident doctors working in hospital owned either by government or wealthy individuals, it becomes expedient for us to discuss the liability of hospital management as well.

The rationales for discussing the liability of hospital management are two: First, there is a relationship of master and servant between the hospital management and the doctors working under their employ and by the doctrine of Respondent Superior the hospital management will become vicariously liable for the negligent acts of the doctors; Secondly, the hospital management itself as an organization which takes the performance of function requiring skill is under a duty to take care and it is a settled principle of the law that whoever is under a duty to take care, cannot escape that responsibility by shifting it on to someone else[67].

The position of the law was first of all that the hospital management's duty was that of ensuring that it gets qualified doctors to come and work in the hospital and that once this duty was satisfactorily discharged, the management would not later be held liable for the negligence of any of its doctors. The argument then was that as professional their contract is for services and not of services. Thus, in the case of Hillyer v. The Governors of St. Bartholomew's Hospital[68], the court was of the view that the only duty undertaken by the Governors of a public hospital towards a patient who is treated in the hospital was to use due care and skill in selecting their medical staff. That the relationship of servant and master does not exist between the governors and the physicians and, other attendants assisting at an operation also cease at that time to be the servants of the Governors[09]. What happened in that case was that, the plaintiff on March28th, 1970, entered St. Bartholomew Hospital so as to obtain a medical examination from an anesthetist. The examination was conducted by

one Charle Barret Lockwood a consulting surgeon attached to the hospital. He was for the purpose of the examination put on an operating table in such a way that his arms hanged over its side. His left arm touched hot water from a tin projecting beneath the table as a result of which the inner upper part of it was burnt and the inner part of his right arm was bruised by the operator, pressing against it during the operation. The injuries he sustained caused him to experience traumatic neuritis and paralysis of both arms thereby depriving him of the ability to practise his profession as a medical man.

Upon bringing an action claiming damages for the harm suffered against St. Bartholomew's Hospital Management, the Court held that the action was not maintainable against them on the ground that there was no relationship of master and servant between the hospital management and the nurse who were assisting the doctor in the operation room because at that time they were completely at the disposal of the doctor and not the hospital[70]. This then, was the first position of the law with regard to the liability of the hospital management for the negligence of their doctors and other staff. While commenting on it, Lord Denning said:

> It cannot help thinking that this error for it was undoubtedly an error - was due to a desire to relieve the Charitable hospitals from liabilities which they could not afford. They are dependent on voluntary contribution and their work could be seriously impeded if they were exposed to heavy claims of this sort

It could be deduced from the speech of Lord Denning that the actual ratio decided of the Hillgers case was not in law, but in law, but in policy consideration. That is to absolve charitable hospitals from liability for the negligence of their doctors so that they could not be grounded by payments of huge amounts as

damages to claimants. This decision must have been taken in furtherance of the doctrine of charitable immunity. This old rule, assures hospitals relying on charitable funds for their operation, of more or less broad immunity from claims in damages for the fault of their servants. Secondly, the court's view here must have been influenced by the difficulty of applying the traditional "control test" for vicarious liability. How, it was though could a surgeon performing an operatic be treated as a servant of a hospital when it was evident that no one could tell him how to do it? However, there was a judicial re-think, leading to a change of trend in this regard, under the pressure of contemporary social trends and developments.

This change was gradual, beginning in 1942, with the case of Gold v. Essex County Council[71]. There was a slight change here, with regard to the law in respect of nurses and radiographers. In that case, an infant was treated by radiographer, an employee of the respondent, at one of their county hospital. As a result of his failure to provide adequate screening materials while giving crenray treatment, the infant suffered injury to her face. In an action against the respondents, the trial court basing their decision on that of Bartholomew's case held that the respondents were not liable for the negligence of the respondent. On appeal, however, it was held that the radiographer was under a contract of service with the respondents and therefore, responsible for his negligence under the doctrine of Respondent Superior.

As earlier stated, the above case changed the position of the law only slightly. They limited themselves only to nurses and radiographers leaving the

position of doctors still unclear. Again, by this decision it means that for the hospital management to be held liable, it must be shown that the employee's contract of employment was one of services not for services. This position was considered to be unsatisfactory and therefore, there was the need for adequate protection of the doctors and nurses working in public hospitals against actions for negligence in the performance of their duties. Thus in Cassidy v. The Ministry of Health[72], the opportunity presented itself. In that case the plaintiff who was suffering from a contraction of the third and fourth fingers of his left hand was operated upon at the defendant's hospital by Dr. F., a whole tome assistant medical officer of the hospital. After the operation, the plaintiffs hand and forearm was bandaged to a split and they remained like that for about 14 days. During this time, the plaintiff complained of pain but, apart from ordering the administration of sedatives, no further action was taken by Dr. F. or the house surgeon who attended to the plaintiff in absence of DR.F. or the house surgeon were employed by the hospital authority under contract of service. When the bandages were removed, it was found that the hand was practically useless. In an action by plaintiff against the defendant for negligence in the post operational treatment, which he received, it was held that there was evidence showing prima facie case of negligence on the part of the persons in whose care the plaintiff was, which had not been rebutted. In view of the terms of employment of DR. F. and the house surgeon, the hospital management was held liable to the plaintiff whether the negligence was that of DR. F. the house surgeon or a member of the nursing staff. In his own judgement, Lord Denning laid down the law that the

liability of the hospital authorities for the negligence of a doctor or a permanent staff of the hospital does not depend on whether he is employed under a contract of service or under a contract for services but rather on he who employs him. So if it is the patient himself who selects his doctor and employs him to treat him the hospital authorities will not be held liable for his negligence but if, on the other hand, the doctor, whether or not he is a consultant, is employed and paid by the hospital authorities, they are the ones to be hold liable for the doctor's negligence while treating the patient. He said:

> It has however been said-that the liability for doctors on the permanent staff depends on whether there was a contract of service... I venture to take a different view; I think it depends on this; who employs the doctor or surgeon, is it the patient himself or the hospital authorities? If the patient himself selects and employs the doctor or surgeon... the hospital authorities are of course not liable for his negligence because he did not employed them. Where however; the doctor surgeon, be he a consultant or not is employed and paid, not by the patient but, by the hospital authorities,I am of the view that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service, of a contract for services[73]

It has been suggested that this decision was based on the transformation of the traditional control test into something resembling organizational test. Integration into the employers' organization is the essential ingredient. Physicians and nurses are considered to be part of the organization of the hospital for implementing the treatment of the patient.

Emphasis on the hospital organizational responsibility was in Jone v. Manchester Corp[74]. In this case, a newly qualified physician was required by the hospital rules to administer anesthestics, in the hospitals emergency room. The hospital has held doubly responsible, being not only in vicarious liability for the

negligence of the physician, who was held to be primarily negligent but being also primarily liable for its "personal" failure so to run its organization that such mistakes would not occur.

After the decision in Cassidy and Jones cases (supra), it has become an established law that hospital management or authorities are vicariously liable for the negligence of their doctors and other supporting staff whether or not the terms of their contracts of employment are that of service. This is the position of the law in Nigeria. Thus, in the case of Dickson Igbokwe v. University College Hospital Board of Management[75] the deceased was admitted into a fourth floor Maternity Ward of the defendant hospital, where she gave birth to a baby on the 23rd of December 1958. After the birth she was suspected of being mentally deranged and was put on sedative drug. A nurse was asked to take care of her. On two sides of the Ward where she was admitted, there was an open verandah about seventy feet from the ground protected by railings four and half feet high. In the morning of 29th December 1958, the deceased was not seen on her bed and was later found dead as a result of injuries she sustained when she fell from the fourth floor,

Her dependants then brought an action claiming damages for the death of the deceased on the ground that the circumstances of her death pointed to negligence on the part of the hospital authority relying on Res Ipsa Loquitur. The hospital Authority agreed under cross - examination that if someone had been specially assigned to watch the deceased, the incident would probably not have occurred. No medical expert was called to show that given the case history aII

reasonable precautions had been taken to prevent the occurrence. The court held that the plaintiff's case was successful since the hospital management had failed to rebut the inference of negligence, which arose from the facts of the case. The court further held that Hospital authorities are responsible for the negligence of the whole of their staff be the surgeons, physicians or nurses or other employees of the hospital.

Thus, from the whole discussion above it is now clear and a settled law that hospital authorities or management are liable, not only for the negligence of their doctors or nurses but indeed all other employees of the hospital. The management of the hospital cannot escape liability by showing that the terms of the contract of the doctor were for service and not of services. Consequently the principle in Hillger v. Bartholomew' Hospital[76], that a hospital was not legally responsible for negligence of its professional staff in matters involving professional care and skill as distinct from matters of purely "administrative" nature, has been overruled.

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CHAPTER FOUR DEFENCES AND REMEDIES FOR MEDICAL PRACTIONERS LIABILITY 4.1. Defences:

In medical professional liability, cases or suits, the burden of proving legal liability of the medical practitioner rests upon the patient. This means that the evidence presented by the patient must be convincing than that presented by the physician. The Physician is presumed to be free from liability until the contrary is proved. The patient must sustain the burden of proof with respect to the essential allegations of his claims against the medical practitioner. If he charges the practitioner with professional negligence, for example he has the burden of establishing the standard of care applicable to the physician, and of proving the practitioner's failure to conform to that standard of care[2]. Secondly, if the patient alleges technical assault and battery by alleging that the doctor operated on him or treated him without his consent, then he has to prove that he did not consent and the circumstance did not call for emergency treatment[3]. Even where the patient-plaintiff has discharged himseif of the necessary burden of proof, the medical practitioner may still not be liable in medical mishap if it can be shown and successfully pleaded that the medical practitioner has a defence to his claim It is some of these defences that we are going to consider under this sub-heading.

The most important of some of these defences are, Contributory Negligence, Voluntary assumption of risk, statute of limitation and special defences. **4.1.1. Contributory Negligence:**

The term contributory negligence has been defined by Kodilinye as, "the negligence of the plaintiff himself, which combines with the defendants negligence in bringing about the injury to the plaintiff"[4]. Judicially, Coker, J.S.C. defined contributory negligence as "Contributory negligence means that the party charged is primarily liable but that the party charging him, has contributed by his own negligence to what has eventually happened"5. The epitome of the two definitions is that, for an act to qualify as contributory negligence, the defendant must have initiated and actually caused the injury complained of and the plaintiff must have aggravated his act, which occasioned the injury. Therefore, for the defence of contributory negligence to come into play, the negligence of the medical practitioner must be concurrent with that of the patient. Consequently, negligence on the part of a patient occurring after the negligent treatment by a physician is not strictly speaking contributory negligence, since it is not concurrent. Another example of contributory negligence is where a patient fails to follow instruction to return for further treatment[6].

The difference between the legal position of the plaintiff and that of the defendant here is that the plaintiff's duty of care is not require to be exercised to any one else but himself in order to avoid the consequences of the defendant's breach of his duty to take care). Failure to exercise it therefore, does not affect

the duty of care required by law to be exercised towards him by any one. On the other hand, the defendant or medical practitioner who is required to exercise due care and deligence in a given condition cannot rely on the want of care of the plaintiff to avoid liability because the duty to be exercised by him still remains intact even with the want of care on the part of the patient-plaintiff, unless of course he can show that he does not owe the plaintiff the duty of care in the circumstance. Therefore, the defendant will be hold liable in negligence even though the plaintiff contributed in causing the damage by his own negligent In awarding damages, however, the role of the plaintiff will be taken into consideration so as to share the amount to be paid by the parties proportionately according to each one's degree of blame worthiness[7], and thereby, reducing the claim of the plaintiff.

At Common law, the position was different from the position discussed above. At Common law, contribution negligence was a total or complete defence, that is, it afforded the defendant complete freedom from liability. So if the medical practitioner was negligent and the patient himself contributed to the negligence occasioning his own injury, he was entitled to nothing by way of damages. According to Lord Blackburn, "The rule of law is that there is blame causing the accident on both side, however small that blame may be on the one side, the loss lies where it falls"[8]. The case, which is regarded as the foundation of the doctrine of contributory negligence, is Butterfied v. Forrester[9]. In that case, the defendant wrongfully obstructed a street in Derby by placing a pool across it, and the plaintiff rode along the street, 'at eight O'clock in the evening of August,

when they were just beginning to light candles' but even though there was still enough light to notice the obstruction, the plaintiff all the same collided with the pole as a result of which he was thrown off from his horse and injured. It was held that the plaintiff had no cause of action, because he could not-withstanding the defendant's negligence, have avoided the accident, by the use of due care.

Thus in the American case of Heating v. Spicer[10], a patient who failed to cooperate with his physician by carrying out all reasonable and proper instructions although his failure combined with the negligence of the physician in creating the proximate cause of his injury, could not recover.

The position of the common law, as illustrated by the above case was therefore, no doubt applicable in Nigeria before the enactment of the laws on contributory negligence. Okoli v. Nwagu", relates to an accident, which took place before the coming into force of the Eastern Region's Fatal Accidents Laws of 1956. The deceased alighted from a bus, walked on the kerb beside the bus onto the front of the bus and, as he was crossing what was a busy road, at a short distance from the bus, a lorry coming along, from the direction leading to the back of the bus, collided with him and dragged him a short distance before the lorry stopped. He died as a result of the wounds. The trial judge dismissed the case. On appeal, it was held that, the respondent driver could not have averted the collision as there was no sufficient separation of time, place and space for him to do so. It was the deceased own negligence that caused the accident.

As time went on, the common law position was found to be harsh and the courts introduced the doctrine of last opportunity Rule, as a way out. According to this doctrine, the plaintiff could recover damages even if he contributed to the negligence, if at the time of the acoident, the defendant could have avoided it, while the plaintiff could[12]. This doctrine, to an extent, mitigated the harshness of the common law, by allowing the plaintiff who was in contributory negligence to recover in some instances.

In order to further protect the plaintiff, who was a contributory negligence the Nigerian Government passed the Civil Liabilities (Miscellaneous Provisions) Act, 11961. This Act, enables a plaintiff who is in contributory negligence to recover damages, although his degree of contribution will diminish the amount of damages due to him. Thus, in the case Oyalowo v. M. De Bank Transport Ltd. 13, the plaintiffs tanker was driven along the main Abeokuta-Lagos road when the defendants trailer, which had been stationary by the side of the road and near a narrow bridge, suddenly and without warning pulied out into the road, causing the plaintiff's driver to swerve to the right and the tanker somersaulted into a ditch. The Western State Court of Appeal upheld the judgment of the trial judge that the defendant driver had been negligent in pulling out suddenly and without warning from stationary position into the main road, but that the plaintiff's driver had been in contributory negligence. The trial judge's assessment that the defendants and plaintiff were to divide the damages between them at 60 and 40 percent respectively was accordingly upheld.

The Present position of the Law, as could be seen from the Law Reform (Miscellaneous Provisions) Act, 1961 and the case of Oyalowo is that where a patient is in contributory negligence, the amount due to him by way of damage will be reduced by the percentage of his own contribution to the injury. Thus, failure of a patient to return as instructed for further treatment has afforded a defence in a number of cases[14]. If the patient is aware of the injury he has sustained and goes to another physician, his failure to return as instructed does not afford a defence[15]. Also, in the absence of instructions, the failure of a patient to return for further treatment is not contributory negligence[16]. At least one court has held that, with respect to following instructions, a sick man should not be held as strictly accountable as a healthy man.

It should be noted that the defence of contributory negligence is not frequently applied in medical professional liability cases. The doctrine of superior knowledge on the part of the doctrine makes such a defence dangerous and difficult. The patient is usually inactive at the time of the treatment and usually placed himself in the hands of the physician. There are some instances, however, in which contributory negligence of the patient and the negligence of the practitioner as the sole proximate cause of the injury have been raised as a defence[19]. **4.1.2. Assumption of Risk (Volenti Non Fit Injuria).**

Voluntary assumption of risk (Volenti Non Fit Injuria) as a defence, means that anyone who agrees, either expressly, or impliedly to the risk of injury cannot recover damages for any of the risks he had agreed to run[20]. The position of the

law here is on the philosophy of individualism, that no wrong is done to one who consents[21]. Equally, in professional medical liability, it is a cardinal legal principle that one who knowingly enters upon a course of conduct involving certain risks cannot recover damages for injuries resulting from the conduct. For the rule to apply, however, it must be found that the person injured actually know or that the risks were so obvious that the patient should have known of the risks involved. As a matter of law, for example, one who engages in an athletic contests assumes the risk of injuries that ordinarily occur in such contests.

In medical professional liability suits, the defence of assumption or risks applies to the risk of injury from medical treatment performed with proper care, but it does not apply to risk of negligent medical treatment if the patient had no reason to expect such negligence. For example, where a patient undergoes X-ray treatment, he assumes the risk of radiation burns, which is normally involved but he does not assume the risks of burns resulting from negligent over exposure[22]. Where there is no negligence in the use of X-ray, however, there is no recovery for radiation burns [23]. Again, where an adult patient insisted that his fractured arm be re-broken and reset despite opposition and warning by his physician the patient assumed the risk and could not recover damages when he subsequently lost the use of his arm[24].

A patient, who knowingly, entrusts himself to the care of someone lacking in medical qualifications, assumes the risks arising from such lack of qualifications. Where a patient who had been using drugs for a longtime to control his epilepsy submitted herself to the care of a chirographer knowing that

the chirographer did not believe in the use of drugs, the patient assumed the risk of adverse effects from discontinuance of the use of drugs[25]. One who submits himself to the care of a Christian Science practitioner assume the risk that this method of treatment will not be effective[26].

It is a general rule that a medical practitioner cannot avoid liability for negligence by having a patient sign in advance a release or a contract containing an exculpatory clause. The obligation of a physician to possess and exercise reasonable care in treating a patient is imposed by law[27]. The medical practitioner who undertakes the treatment of a patient cannot therefore avoid that obligation by contract. However, a patient can relieve a medical practitioner of liability for the inherent risks of dangerous or experimental procedures if he gives his consent, having full knowledge of the risks.

It should be noted that there is striking absence of Nigerian cases on assumption of risk in medical suits. This is so because it is the general practice of medical practitioners to inform patients adequately, and obtain their consent in advance, their written authorization for any necessary treatment or operation[28] Secondly, because of high illiteracy level, especially in the Northern part of Nigeria, patients are ignorant of their rights in this respect. And thirdly, religious belief and poverty also militate against the patient's desire to bring actions against medical practitioners for medical mishaps. The population should, therefore, through the mass media, the churches and mosques be educated that it is a religious, social, and legal right to sue for medical mishaps, The government should also allocate funds to the Legal Aid Council, to assist victims

of medical mishaps who, because of poverty cannot initiate legal proceedings to vindicate their rights against negligent medical practitioners. 4.1.3 **Statute of Limitation.**

It is the policy of the law in Nigeria to require a person who is injured by another to seek legal redress as soon as possible. A delay in doing so may result in an injustice since the passage of time makes proof of the factual events more difficult. For all states in Nigeria have established time limits for filing suit tort. Nigeria, there is no specific statute applicable to medical professional liability suits. Consequently, a suit charging a medical practitioner with professional negligence is usually regulated by the general statutes of limitations applicable to torts.

Limitation of action is defined in Black's Law Dictionary[29], as a certain time allowed by statute for bringing litigation. This means that once the time allowed by Law for the purpose of instituting an action in respect of a particular act expires, the person intending to institute that action is debarred by law from doing so and where such an action is instituted it will be declared as statute-barred and consequently be dismissed by the court.

With regard to torts, this will mean the period within which a party who sustains injury or damage as a result of the act of another is entitled to maintain an action in court to recover damages. The laws governing this in Nigeria are the Limitation of Action Act, 1966[30]. The Public Officers Protected Act[31], and the various States Edicts on Limitations of Actions[32].

Under the Kaduna State Limitation of Actions Edict[33], the limitation period for actions to recover damages for personal injuries is give years and where the person died before the affliction of the period stated above, the period allowed with regard to the cause of action surviving for the benefit of his estate is five years[34] again, where the accident results in an instant death, the time allowed the dependants or the personal representatives of the deceased to institute an action for the benefit of estate is five years. Any attempt to institute an action outside the limitation period will fail. Thus, in the case of Letang v. Cooper[35], where the plaintiff instituted an action based on trespass to the person, when the defendant's car accidentally ran over her legs when she was sunbathing on the grass. It was held that her proper cause of action was in negligence and not trespass to the person. And that since the case was brought outside the 3 years period allowed under the Limitation of Period Act[36], for bringing an action in trespass, it was statute barred.

In the Nigeria jurisprudence, there quite a number of decisions. One of which is the case of Ogunsan v. Iwuagwu[37]. In that case, the plaintiff brought an action against the defendant jointly and severally for the sum of £5,000 being special and general damages for negligence of 1st defendant in that, on the 16th of May, 1965, the 1st defendant in course of his employment as servant of the 2nd defendant drove and managed the 2nd defendant's bus so negligently that he knocked down the plaintiff and caused him serious injuries.

Before hearing the case, Counsel for the defendants applied that the question whether the action was already statute barred or not be determine first.

He submitted that in view of section 2 of the Public Officers Protection Act, the Action should have been brought 3 months from the date of the accident when the cause of action arose. He further contended that the 2nd defendants could also take advantage of the protection afforded by the Act in view of the fact that section 2 gives the protection to any act done in pursuance or execution or intended execution of any Act or law or of any public duty or authority.

The 2nd defendant was running the transport service in pursuance of a power given to it by section 141 (8) of the Lagos Government Act, and by Section 18 of the Interpretation Act, the further contended, that the defendant came within the meaning of the words any person" in Section 2 of Public Officers Protection Act. The 1st defendant was an employee of the 2nd defendants. Instead of bringing the action within 3 months as provided, the plaintiff brought it 26 months after the accident. The counsel further averred that even if only the first defendant was held to be covered by the Act, then the action against the 2nd defendants must also be dismissed.

It was held, inter alia, that the first defendant came within the Protection afforded by section 2 of the Act and that the action not having been taken within 3 months of the accident could not lie against him. And that since the second defendants, were sued as joint - tortfeasors, the rule is that where there is a joint cause of action against two or more persons, a discharge as against one of them operates as a discharge against all. The action was therefore dismissed.

Another important Nigerian case is Adigun v. Ayinde[38]. Again, in this case the plaintiff sued the defendants jointly and severally for N700,000 being special

and general damages for the injury sustained by him as a result of the negligent driving of the first defendant. The injury was sustained on the 10th February 1978 while the suit commenced on the 17th of August 1981.

The defendants raised an objection to the suit on the grounds that the suit being founded on tort, cannot be brought against the third defendant which is an organ of the Federal Government because of the doctrine of state immunity from tortuous liability; that the second defendant, Permanent Secretary, Federal Ministry of Agriculture and Natural Resources is not a juristic person and as such, cannot be sued; and thirdly that the action being against Public Officers (1st and Second defendants), is statute barred as it was not commenced within 3 months from the date the cause of action arose in compliance with section 2 (a) of the Public Officers Protection Laws Cap. III, Laws of Niger State. Counsei to the plaintiff on the other hand contended that the action is not statute barred in that negligence occurred on the 10th of February 1978, but the injury suffered by the plaintiff was continuous.

It was held on the issue of limitation of action that continuance of injury or damage means continuance of the Legal injury and not merely the injurious effects of the Legal injury. Therefore, the plaintiff should have, commenced action 3 months after the date of the accident and not after the date of his final discharge from the hospital. This position of the Law applies to medical professional liability in its entirety.

The next question is, when does the period of limitation begin to run? According to the Kaduna State Limitation of Action Edict, 89 it would appear that

time begins to run for the purpose of determining whether or not an action is within time, on the particular day the cause of action accrued[40]. However, there are certain cases in which this can be extended. One of such cases is where the injuries sustained by the victim of the defendant's negligence leads to his death. Here, the position of the law is that the computation of time shall begin from either the date on which the deceased died or on the date in which the personal representatives of the deceased became aware[41].

Another area in which the time could be extended is that of fatal accident. Here time begins to run on the date of the death of the person involved in the accident, or on the date the person for whose benefit the action was instituted became knowledgeable about it[42]. This means if the person for whose benefit the action is instituted is not aware of the death of the deceased or the reason for his death until after one year of the occurrence of the accident, then the time begins to run after that one year and not the date on which the accident actually took place.

Another situation that will lead to the extension of time will be where the person entitled to institute the action was under disability at the time the cause of action accrued. This particularly relates to infants or persons of unsound mind[43]. Such persons are allowed to bring actions anytime before the expiration of five years. From the date when they ceased to be under such disability or die[44]. This means that if an infant sustains injuries as a result of somone's negligence, the computation of time for the purpose of determining whether or not his action is statute-begins on the date he attains majority. And if he is a lunatic it is on the

date the lunacy or madness ceases. However, they could sue through their next friends to avert this apparent delay.

Another situation that may lead to extension of the limitation period is where the person who has the right of action is under confinement[45]. The law here is that if on the date the action accrues, the person in whose favour it accrues is under confinement, then such an action can be bought at anytime before the expiration of the five years after the date when the person ceases to be under confinement[46].

Similarly, where the negligent act was committed when the person against whose interest it is committed is abroad, the law is that the period of limitation can only begin to run when such a person returns to Nigeria. This provision seems to relate to loss of property (tangible or intangible) and not personal injuries since one cannot be injured physically at a place where he is not there[17].

One other thing, which the Kaduna State Limitation of Action Edict provide for, is where the accrual of the Cause of Action is concealed by the defendant so that the time elapsed before the person entitled to sue becomes aware. The position under the Edict is that, the period of limitation will not begin to run untill the plaintiff has discovered the fraud or could with reasonable diligence had discovered it[48]. Finally, once time has started to run, there will be no suspending it for any reason[49].

In conclusion, it would be said that, any action against a medical practitioner outside the limitation period, unless it falls under the above exceptions, will be time barred.

4.1.4. Special Defences

Besides the more common defences discussed above, there are some less usual defences that may be available in a suit against a medical practioner in appropriate circumstances. These defences that may be available in many kinds of suits and are not used too frequently in professional liability suits. Nevertheless, it is important to discuss them and know about them, in case the need arises for their application.

4.1.4.1 **Release:**

A release is an agreement in which some interest is surrendered to the person against whom it could be enforced. For example, Makolo, a patient agrees with Kharmal, a gaenacologist, to treat her without fee and that if any medical mishap arises from Kharmal, she will not sue him. If valid, a release is a complete defence to a suit to enforce the surrendered claim.

For a release to be valid, the person giving it must be competent. It must not be obtained by fraud, fraudulent misrepresentation, duress, or undue influence. An innocent mistake will not ordinarily affect the validity of a release, but a mutual mistake is frequently recognized as grounds for the avoidance of a release. Since a release is a contract, it must be supported by valuable consideration unless it is intended as a gift. A release of liability for future negligence is contrary to public policy and is null and void[50].

As a general rule, a release given to one of several joint tortfeasors has the effect of releasing all of the others, even though an express reservation of right to sue the others is made. A covenant not to sue, however, does not have

this effect. Where a release clearly indicates that it is given in exchange for only partial satisfaction, the other tortfeasors are not completely released, but the amount received may be credited as a partial discharge of their obligation. Under the modern rule, one tortfeasor who has satisfied a judgment for the tort may bring suit for contribution by the other joint tortfeasors. A release of one of a number of persons who severally, but not jointly, are liable for a tort, releases the others if each of the tort-feasors is liable for separate injuries, unless it is expressly agreed that it shall do so[51].

A physician's relationship with his patient is one of confidence. He has and obligation to disclose to the patient, any injury suffered or any negligent conduct on his part. His failure to do so, may constitute fraudulent misrepresentation which would invalidate a release. Thus, a release obtained by medical practitioner from a patient whose heel was burnt by not water bottle while he was under a general anaesthetic, was set aside where the patient testified that the signed the release because of misrepresentation by the physician[52].

Where a person suffers injury as a result of the negligence of another and is sent to a physician, the negligence of the physician may aggravate the injury If the patient executes a general release to the person who caused the original injury, that release is a defence to a suit by the patient against the doctor if the injured person is negligent in his selection of a physician, however, the original wrongdoer is not liable for aggravation of the injury by the physician's negligence, and a release of the original wrongdoer does not release the physician[54]. Even if the injured party is not negligent in selecting a physician, the original wrongdoer

is not liable for a distinctly new injury caused by the negligence of the medical practitioner and the medical practitioner is not absolved by a release to the original wrongdower[55].

In conclusion, it may be said that a valid release to a treatment or operation by a patient, is a complete defence to any suit subsequently brought by him on that same subject matter against a medical practitioner.

4.1.4.2 **Res Judicate**

Res judicata means that once a legal claim has been finally decided on the merits, it cannot be relitigated between the same parties. This is known as the rule of res judicata. A decision on the merit is reached when it is a declaration of law with respect to the rights and duties of the parties, base upon the state of facts disclosed by the pleadings and the evidence. A judgment against one of a number of joint tort-feasors, if satisfied, bars a subsequent suit against the other joint tort-feasors[56].

This defence is available in suits against medical practitioners for professional liability in negligence or in torts generally. A judgment in favour of a medical practitioner in a professional negligence suit is a bar to a separate suit for breach of warranty arising out of the same transaction[57,] It is sometimes applied to bar a suit for professional negligence where the physician has recovered a judgment for compensation for his services, on the theory that the suit for compensation resolves the issue of physician's care and skill, even though the issue was not directly litigated[58].

4.1.4.3 Compensation Awards

Workmen compensation laws, provide for compensation to employees for injuries suffered in the course of employment, including necessary medical services. An employee who has been awarded compensation for his injuries as provided for under the statute, is barred from suing a medical practitioner who treated him for injuries resulting from the alleged negligence of the doctor. This is in line with the proposition in the Workmen's Compensation Act[59], which provides in section 24 that:

> Where injury in respect of which compensation is payable under this Act was caused in circumstances creating a legal liability in some person other than the employer to pay damages in respect thereof - (a) the Workman may take proceedings both against that person to recover damages and against any person liable to pay compensation under this Act for such compensation, but shall not be entitled to recover both damages and compensation...

According to this provision, if the injury which the patient or plaintiff suffered, entitled, him to compensation under this Act, and is also capable of giving rise to a cause of action for damages against a third part, that is, someone other than the employee (medical Practitioner), if the patient or workman has been compensated according to the Act, will be barred from suing in tort for damages and vice versa. This is defence in medical professional liability.

4.2 Remedies For Medical Practitioners Liability

When it becomes established in a medical professional liability suit that the defendant is liable, one thing becomes obvious. That is, what remedy to the aggrieved party entitled to? The objective of medical liability suit is always to

claim damages or compensation foi the injury sustained. And in order to arrive at the amount and the nature of damages that the patient plaintiff is entitled to it is necessary to know whether the damages are for personal injuries or for death.

Damages are the pecuniary or monetary compensation that may be recovered in a law suit for the breach of some duty or the violation of some right recognized by the law[60]. Damages may be recovered either for breach of a contractual obligation or for a neglect of duty or an invasion a right recognized by the law: (1) nominal damages (2) compensatory or actual damages and (3) punitive or exemplary damages.

Nominal damages are the token compensation that may be recovered where no tangible loss or injury has been suffered or where there is no proof of the amount of the loss or injury. Such damages are awarded to vindicate the right that has been invaded, even though the circumstances do not justify an award of substantial damages.

Actual or compensatory damages are the monetary compensation recoverable for injury or loss suffered as the natural and probable consequence of a wrongful act or omission. They are either general or special damages. General and special damages will be discussed later in this chapter.

Punitive or exemplary damages are monetary compensation over and above actual or compensatory damages awarded as a punishment or deterrent, because of the wanton, reckless, malicious or oppressive nature of the wrong committed. In a suit against a medical practitioner for professional liability the general rules with respect to damages apply. These rules vary somewhat,

depending on the type of suit involved-breach of contract, negligence, assault, battery etc. This paper does not purport to give an exhausive study of all the legal rules relating to damages but, rather, a brief review of the most important rules, particularly as they apply to suits against medical practitior. for professional liability. Damages shall be discussed under two heads; that is damages for personal injuries and damages for death. 4.2.1. **Damages for Personal Injuries**

Damages in a tort action are awarded in a lumpsum. The award is claimed once and for all with no possibility of decreasing or increasing it later, because of changes in the plaintiff's situation. As a corollary to this, the plaintiff patient must sue in one action for the totality of his losses, past, present and the future. He may not explain his cause of action by suing separately for different heads of damages. Nor can be resisting his damages being calculated or being assessed once and for all. The judge, therefore, has to make certain predictions as to what would have happened to the plaintiff in the future if he had not been injured. Secondly, the judge may have to make predictions as to what may likely happen to the plaintiff in the future. This can only be resolved on a hunch or are based on statistical evidence[61]. In very exceptional cases, there cannot be a variation of the award as a result of changes accruing soon after the tria, This power is discretionary[62]. The overriding purpose of tort law is to compensate the injured party and not to punish the defendant. Hence, the overriding principle is to indemnify the victim for the loss he has incurred or suffered. Hence, unrelated

but subsequent events may be taken into consideration. E.g. a widow's remarriage or a victim's premature death from other causes[63].

Allowance is also made for benefits, which offset losses. Such benefits must have been caused by the tort. The strict application of the indemnity principle prevents the plaintiff from enriching himself through an accident. Nevertheless, full compensation is always awarded to the plaintiff[64].

Damages for personal injuries in a medical professional liability suit are usually divided into two types:- Special and General damages. 4.2.1.1.

Special Damages:

Special damages are compensation for expenses that are a natural consequence of the injury but are not a necessary consequence of the injury. They arise from the special circumstances of the case and the amount of the value of the injury or the loss must always be proved. Special damages consist of out of pocket expenses and also of the loss of earnings incurred before trial. It is possible to calculate exactly what they amount to. Special damages must be specially pleaded. They seek, to effect a "restitution in intergrum". That is, to put the plaintiff in the position that he would have been, had the injury not been inflicted on him. It would be necessary to discuss some of the items of special damages.

A) **Medical, Nursing And Hospital Expenses.**

The plaintiff is entitled to recover such expenses, which he has reasonably incurred up to the time of the trial[65]. They must be pleaded as special damages

His prospective expenses will be estimated as part of general damages. The reasonableness is in relation to the plaintiff's condition in life and also to the amount paid. Any savings to the plaintiff, which is attributable to his maintenance at public expense, is set off against any loss of earnings. Where the plaintiff is nursed by a member of his family or friend, he is entitled to a reasonable cost of such nursing, even though he is not under any legal or moral obligation to pay the person who gives services[66]. B) **Loss of Earnings**

Loss of earnings up to date of trial forms part of special damages. Such losses are computed after making deductions, which would have been made by way of tax. Loss of perquisites (fringe benefits), such as a service car are also compensable. Prospective loss of earning is also recovered as genral damages. The courts estimate the plaintiff's future employment prospects, his future incapacity and the number of working years of which he has been deprived of. This is done by ascertaining the plaintiff's annua! earnings immediately before the injury. This figure may increase or decreae by positive evidence as to future prospects. The figure is taken as the "multiplicand". The courts then choose a "multiplier", by which the multiplicand will be multiplied in order to make a lumpsum award. This is reached by taking into account as against the expected years of employment, all the imponderables (improbabilities), such as, illnesses, early deaths, unemployment, as well as, the vital factor of accelerated payments in the form of lumpsum award. This assessment is subjective i.e., the plaintiff is taken for what he is, in the light of all the evidence. The calculation is

concluded by multiplying the multiplier by the multiplicand. In view of the uncertainties and the acceleration factor, the multiplier of more than 16 is rare[67].

Actuarial evidence may be admissible in aid. The courts generally refuse to take into account future inflationary trends. Where the injury has reduced the number of years, which the plaintiff is expected to live, damages are awarded for the whole period of his pre-accident work in life expectancy with a reduction of living expenses, which he would have incurred during these "loss years". Although commonly spoken of as loss of earnings the new favoured view is that the loss for which the plaintiff is entitled to compensation is not the future loss of earnings, but the present impairment of the capacity to earn. Hence, loss of earning is also awarded to young children[68]. Where an illness unconnected with the injury supervenes before the trial and causes more incapacity than the Injury caused before the trial, the award of the loss of earnings is reduced to take account of that supervening illness[69]. C) **Other Pecuniary Losses**

There are a host of other pecuniary losses arising from medical professional liability. For example, where a house wife is injured with the result that her capacity to carry out her domestic duties is impaired, she can claim damages based on estimated cost of employing someone else to carry them out whether she in fact desires someone else to carry them out or to do so, is irrelevant. The plaintiff may also claim for the inability to carry out a profitable hobby, as a result of the injury. Whenever a tort causes a pecuniary loss, the plaintiff can recover in medical professional liability[70].

4.2.1.2 **General Damage**

General damages are monetary compensation for those items of injury or loss that are the natural and necessary consequence of the wrong and that are implied by the law from the fact of the injury. The monetary amount or value of the loss or injury does not have to be specifically proved by evidence. General damages are not susceptible to exact calculations. General damages are implied by the law. They include, future loss of earnings, pains and sufferings, loss of amenities, loss of expectation of life disabilities and disfigurements[71]. We shall now consider some items of general damages. A. **Pains And Sufferings:**

A medical practitioner is liable to a patient for causing pains and sufferings. However, a patient is only entitled to damages if that pain and suffering is the natural and probable consequence of the physician's negligence. Compensation is not allowed for pains and sufferings arising from the original ailment for which the patient was treated or for that following as a natural consequence of an operation performed with due care and skill[72]. The pains and sufferings may be actual or prospective caused by the injury of subsequent surgical operations.

A patient abandoned during pregnancy was entitled to damages against a medical practitioner for unrelieved pain suffered during child birth[73]. Where a woman had a miscarriage, she was not entitled to damages against a physician who failed to attend to her either for the miscarriage or for the suffering that

would usually attend such an occurrence, but she was entitled to recover for the pains that could have been prevented or eased if he had beer present[74].

In the absence of any logical process for assessing general damages, the courts and statute have evolved a conventional scale or tarrif, acceptable to the prevailing sense of what is fair and equitable[75]. This does not mean that an objective standard is required or to be established in determining the amount of damages to be awarded for pains and suffering. It is usually left to the discretion of the judge[76]. With respect to future pains and suffering, the duration must be considered based on the patient's life expectancy at the time of the trial not his life expectancy prior to the injury[77].

Claims under this head cover shock and mental torment to the plaintiff's knowledge that his life has been shortened[78]. For a claim for mental anguish to succeed, there must be physical injury. Thus, in Cooper v. National Motor Bearing & Co.[79], a patient developed cancerophobia in connection with negligently caused x-ray burns, when advised by another physician that cancer might result, recovery of damages for mental anguish was allowed. A patient who suffered injury of a nerve as a result of negligent treatment of an Olecranon fracture was awarded damages where the injury resulted in pains, numbness, stiffness and where, when he considered returning to work he became nauseous and lost interest in live[80].

B) Loss of Amenities

This is sometimes called loss of enjoyment of life or loss of faculty. The plaintiff can claim for any loss of bodily function. Such damages cannot be refused because the plaintiff will be unable to enjoy the damages because of the severity of his injuries. This embraces such losses as the deprivation of society, loss of marriage prospects and it is similar to pains and sufferings. The courts recognize a dual loss-the actual loss of enjoyment of life and the sufferings caused by the awareness of it. Unlike pains and sufferings, which are conventional, very substantia! damages have been awarded for this head[81].

C) **Bodily Harm.**

This is the most obvious loss in personal injury action. The loss or impairment of some parts of the body. Where a physician performs an operation without the consent of the patient, the patient can recover damages for the resulting bodily harm. This may be more or less psychological than physical[82].

Following the above discussion it is obvious that any professional mishap on the part of medical practitioner may give rise to a very colossal financial consequence. This cost implication may have a negative effect on the volume of medical practice likely to be carried out. This will have a negative effect on the supply of medical practice likely to be carried out. This will have a negative effect on the quantum of medical practitioners. In view of the fact that the ratio of doctor patient is very low compared to our contemporary need, it is recommended that, medicai practitioners should be very careful in handling the treatment and operation on their patients and also to take up third-party

comprehensive insurance policies. This will reduce their cost of medical practice in the event of likely professional mishap. 4.2.2. **Damages For Death**

When there is a medical professional mishap resulting into death two issues arise. First of all the deceased's estate or executors may wish to proceed with a cause of action which the deceased himself would have had, had he lived. And secondly, others, especially relatives may claim that they have suffered a loss in consequence of death.

If a tort has been committed in medical professional practice and the patient dies, the question is whether the cause of action survives. At Common Law, the death of a party extinguished any existing cause of action in tort by one against the other. This was based on the Latinism; action Personalis Muritur Cum Persona". But later on, the defect of the law forced on the attention of the legislature by the growth of motor traffic accidents and the trend was reversed. The introduction of compulsory third-party insurance for motor cars made it unjust that if the defendant killed his victim instead of maiming him he could escape civil liability. Because of this defect in the law, The Law Reform (Miscellaneous Provisions), Act, 1934 was passed. The 1934 Act, removed the rule that action did not survive death although the 1934 Act, allowed for the survival of the cause of the deceased person, it did not create as such, any new cause of action. That is to say, the Act did not create liability. It simply preserved the deceased's subsisting action for the benefit of his estate[83]. This statute merely legitimized or gave legislative blessing to a quite separate

common law rule which provided that, "death could not give rise to a cause of action in other person," although they were dependent on the deceased. This was derived from the ruling of Lord Ellen borough in Baker v. Bolton[84], the "in a civil court, the death of a human being could not be complained of as an injury."

The principle of survival of action does not create difficulties for damages accruing during the deceased's lifetime, e.g. deceased was injured by a medical practitioner during an operation caused by the physician's negligence and died three months later. The estate will recover damages for pecuniary ana non-pecuniary losses accruing after death. The action was not for death caused by the defendant and so the defendant needed not be responsible for the death. But where the defendant's wrong had caused the death, then any losses or gains to the estate consequent on the death are ignored in the calculation of damages[85]. An example of a loss would be the termination of annuity and an example of a gain would be an insurance payment. One exception to this one is that, the court may award the estate any funeral expenses incurred[86].

It has become a settled law today in Nigeria that death can give rise to a cause of action. The applicable law is the Fatal Accidents Act, 1961[87]. The death of a patient arising from a negligent medical treatment or operation can now create a cause of action. This action for death is an action which is entirely new in its quality, new in its principle, and in everywhere new[88]."

The Fatal Accidents Act, 1961 has made considerable in roots on the Common Law rule. An action can now be brought not only to survive the because of the deceased person which he would have brought if he had not died, but

could also henceforth, be brought under the Fatal Accidents Act, 1961 in the name of the Executor or the Administrator of the deceased's estate. And that action lies for the benefit of the deceased's dependants. Fatal Accident Act, 1961, provides in Section 3(1) that; where:

> The death of a person is caused by the wrongful act, neglect or default, and the wrongful act, neglect or default is such as would, if death had not ensued, shall be liable to an action for damages, not withstanding the death of the person injured.

The provision is indicative that the death of a person can give rise to a cause of action that is entirely new.

It must be shown that the plaintiff caused the death of the deceased wrongly. That is to say, the death must have been negligently or through the default of the defendant[89].

b) The deceased must have died as a result of the injury inflicted upon him by the wrongful act of the defendant[90].

c) That if the plaintiff had not died, he would himself had been entitled to maintain that action to recover damages suffered. If the deceased had accepted any sum, while he was alive, in full satisfaction of his claims against the defendant, his estate cannot succeed in an action for his death, thereafter[91]. If the deceased was found to be in contributory negligence, that would cause a reduction of the recoverable damages by the plaintiff[92].

d) The plaintiff must proove that the loss accrued qua family relationship and not qua business relationship. Thus in Malyon v. Plummer[93], the plaintiff had been paid £600 per annum for services rendered to her husband's company. The

value of these services was calculated at £200 per annum. The balance was attributable to her relationship with the deceased. Her loss of dependency was therefore £400 per annum. Again, the plaintiff must have suffered some pecuniary loss arising from the death of his breadwinner there must be a loss of prospective pecuniary advantage as opposed to a merely speculative advantage. It is not essential that the dependant should have a legal right to that claim. That services or aid were to be given gratuitously is enough. Thus, in Bello v. Attorney General of Oyo State[9,1], deceased's dependants; i.e. the appellants, for the wrongful death of their breadwinner, caused by the respondents. In the instance case, the deceased, one Nasiru Bello, had been sentenced to death for armed robbery. While his appeal was still pending his execution warrant was issued by the state governor, upon the advice of the State Ministry of Justice. Consequently, he was executed, even though his appeal had not been heard and determined. Being aggrieved, his dependants, including his parents, wives, and children, brought an action against the Attorney-General of Oyo State, claiming the sum of N100,000, as damages for the wrongful killing of their bread winner.

The trial judge dismissed the plaintiffs claim on the ground that, at Common Law, no one can recover damages in torts for the death of another, though the execution of the deceased while his appeal was pending was wrongful and unconstitutional. The Court of Appeal again dismissed the plaintiff's claim in that they had no cause of action under the tort laws of Oyo State. Being dissatisfied, the plaintiff's further appealed to the Supreme Court of Nigeria, which unanimously allowed the appeal.

A claim could be brought for bereavement by a husband or wife. Even parents of an unmarried child may claim for bereavement. The damages here are for mental distress at the death. Actually, the measure of damages is the amount of pecuniary loss suffered by the plaintiffs or defendants' as a result of the death. That is to say, the amount of pecuniary advantage of benefit, which is reasonably probate, the dependants would have got if the deceased has not. died. The pecuniary advantage could have been in kind or derived from services and not necessary in cash. Thus, in Berry v. Humm[95], a workman was held entitled to recover damages for the death of his wife because she used to do his housekeeping and on her death, he had to employ and pay a housekeeper who was not able to manage as economically as his wife used to do.

A plaintiff could also recover damages if it can be shown that there is a reasonable expectation of wages to be earned in the future, to the dependants, especially in the case where the deceased was in school. Thus, in Taff Vale Rly.v. Jenkins[96], the deceased was a girl of 16 years who was nearing the completion of her apprenticeship as a dressmaker and wouid have been likely to earn a substantial income in the near future. It was held that the patents were entitled to recover damages.

If the deceased could have had a defence raised successfully against him by the defendant, then the dependants may have the same defence raised against them. Volenti or ex turpi causa will bar the claim. Any contributory negligence on the part of the deceased will be reflected in a deduction of damages.

In assessing damages in respect of a person's death, any benefits which have accrued or may accrue to any person from his estate or otherwise as a result of death are disregarded. Therefore, any insurance money, pensions or damages for pains and sufferings inherited as part of the deceased's estate are disregarded[98].

In assessing damages, the actual pecuniary loss, resulting to each

dependant from the death up to the date of trial, is assessed separately. The method of assessing damages was stated by Lord Wright in Davies v. Powell Duffryn Collieries Ltd".

> The starting point is the amount of wages, which the deceased as earning, the ascertainment of which to an extent may depend upon the regularity of his employment. Then there is an estimate of how much was required or expected for his own personal and living expenses. The balance will give a datum or base figure which will generally be turned into a jumpsum by taking a number of years' purchase. That sum; however, has to be taxed down by having due regard to uncertainties[100].

The above quotation is an epitome of how damages for medical professional mishap, leading to death may be calculated.

An award may be made from the date of death up to the date of trial. The earnings the deceased would have made are calculated and the sum he would have spent on his own support is deducted. The second stage is to assess losses into the future. The annual value of dependency is estimated (the multiplicand) and the appropriate multiplier used. The aim is to give a lumpsum which, when invested, will produce an income equivalent to the dependant's loss of income over the period of dependency. This will give a global figure, which is available for distribution between the dependants.

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4. See Kodilinye G. Nigeria Law of Torts. Spectrum Law Publishing, Ibadan, 1990, P.83.
5. See the case of Evans v. Baker (1973) S.C.P. 80
6 See the case of Gerber v. Day, 119 Cal. App, 446, 6 P. 2d 535 (1931).
7. See Section 17 of Kaduna State, Torts Edict, No.8. of 1990, also Section 11 of Civil Liabilities (Miscellaneous Provisions) Act, No.33,1961 Section 1 of the Law Reform (Contributory Negligence) Act, 1945.
8. See the case of Cayzer, divine and Co. v. Carron and Co.(1884), 9A.C.873 at 881.
9. (1809) 11 East. 60.
10. 92 See. App.499 (1900).
11. (1960) 5FSC.At P. 16, See also the case of Oyalowo v. De Bank Transport Ltd. (1973) 2 W.A.C.A. 35.
12. See the case of David v. Mann (1842) Lo. M and W.
13. (1973)2W.A.C.A. at 9.35
14. Gerber v. Day, 119 Cal. App. 446, 6 P.2d 535 (1931), Hanley v. Spencer,108
15. See George v. Shannon, 92 Kan. 801, 142 P.9967 (1914).

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17. Shannon v. Ramsey, 288 Man 543, 193 N.E.

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19. Crawford Morris R. And Alan R. Moritz. Doctor And Patient And The Law, C.V. Mosby Co. Saint Louis, 1971, P.410.

20. See Charlsworth Op. Cit P. 755 Para.1230

21. See Fleming Op. Cit P.239.

22. See Ballance v. Dunnington (Supra).

23. Facer v. Lewis 377, 106 (1954).

24. Gramm. V. Boener 56 Ind. 497 (1877).

25. Kirschner v. Keller 70 Ohio. App. 111, 42 N.E. 2d 463 (1942)

26. Spead v. Tomlinson 73 N.H. 46, 59 A. 376 (1904

27. See the case of Walden v. Jones 289 Ky. 395,158 S.W.2d 609 (1942)

28. See Fig. 1, in Chapter Three.

29. See Henry Campbell Black: Black Law Dictionary, Page 835.

30. No.88

31. Cap. 379, Laws of the Federation, 1990.

32. See, for example, Kaduna State Limitation of Actions Edict, 1990.

33. Ibid. Section 19(2-3), with regard to personal injury, the Limitation period is 3. years, while under the Public Officers Protection Act, it is 3 months, See Section 88 and 2 of the Acts, respectively.

34. Ibid. Section 20. The same Limit applies to the State, Pulic Authorities And Officers.

35. (1964) 2 Q.B. 53. See also the case of Long v. Hepworth (91968) I.W.L.R. 11299.

36. Of 1939, Section 2(1).

37. (1968) IANLR. 124

38. (1985) H.C.N.L. 1123.

39. Op. Cit. The Interpretation Act, of 1964 excludes it, See Section 15(2).

40. Ibid. Section 119(2)(b).

41. Ibid. Section 19(2)(b).

42. Ibid. Section 20

43. For the meaning of Infants And Persons of Unsound Mind See Sectic 25(1) Ibid.

44. Ibid Section 25(2).

45. For the meaning of Confinement, See Section 27 of the Act.

46. See Section 28 of the Act.

47. See Section 33 of the Act.

48. See Section 33 of Kaduna State Limitation of Action Edict Op. Cit.

49. See the case of Smith v. Hill (1746) 1W.L.R. 34.

50. Crawford Morris R. and Alan R. Mortz Op. Cit. P. 417.

51. Ibid.

52. Estes v. Magee, 62, 109 P. 2d 631, (1904).

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58. See Onley v. Cavell, 138 Cal. App. 233, 32 P. 2d 181 (1934).

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62. See the case of Mitchell v. Muhholland, (1970) 2.A.E.R. 462.

63. See DR. Monkaree Amadou Op. Cit. at P. 93.

64. See Lim Poo-Choo v. Camden Health Authority (1979) O.B. 190

65. See Cunningham v. Harrison (1975) Q.B. 942.

66. See Donnelly v. Joyce (1974) Q.B. 454.

67. DR. Monkaree Amadon Op. Cit. P. 96.

68. See the case of Olopode v. Komolafe (1978) IL.R.N. 303

69. See Jobbing v. Associated Darrie's Ltd. (1982) A.C. 7994.

70. DR. Monkaree Amadon Op. Cit. P. 97.

71. See Okolo v. Omoru (1973) 3. W.A.C.A. 145.

72. Mc Aliriden v. St. Mary's Hospital Association 28 Idaho 657, 156 P. 155 (1961.

73. Nolton v. Hamilton, 92 Ga. App. 727, 89 S.E. 2d 80S (1955).

74. Mehigan v. Sheehan, 94 N.H. 274, 51 A. 2d 632 1947.

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76. See Crossett Health Center v. Crosswell, 221 Ark. 874, 256 S.W. 2d 548 (1953).
77. See Carlburg v. Wesley Hospital, 182 Kan. 634 323 P. 2d 638 (1958).
78. See Oliver v. Ashman (1962) 2 Q.B. 210.
79. 136 Cal. App. 2d 229, 288 P.2d 581 (1955).
80. See Bowles v. Walder, 241 (1946).
81. See West and Sons Ltd. V. Shephered (1963) 2 A.E.R. 625.
82. See Hively v. Higgs, 120 Ore 1927).
83. Section 1 (1) of The Act.
84. (1808) 1 Camp.193.
85. See Section 1(4) of the Law Reform (Miscellaneous Provision) Act, 19934.
86. John Cooke Op. Cit. P. 280.
87. Fatal Accident Act No.
88. See Lord Blackburn in Seward v. Vera Cruz (1884) 10 A.C. 59 at PP. 70-71.
89. See Bello v. A.G. Oyo State (1986) 5N.W.L.R. Pt 45.828.
90. DR. Amadou Monkaree Op. Cit. P. 101.
91. Atadoghu v. Allade (1957) W.R.N.L..R 184.
92. See The Civil Liability Act of Nigeria, No. 33 of 1916, Part. 3.
93. (11964) 1. Q.B. 330.
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97. John Cooke Op. Cit. P.282.

98. Ibid.

99. (1942) A.C. 601.

CHAPTER FIVE SUMMARY AND CONCLUSION 5.1.

SUMMARY 5.1.1. **Negligence As the Basis of Liability of Medical Practitioners.**

Negligence was defined by Alderson B. in Blyth v. Birmingham Water Works Co. (1856)[1] as,"...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." Simply put therefore, negligence is the breach of a legal duty to take care, which results in damage undesired by the defendant to the plaintiff[2]. Malpractice ordinarily, therefore, implies that the medical practitioner had the consent of his patient to treat him, but such treatment did not conform with the standards imposed on the medical practitioner by law. In medical professional liability litigation, the trend has been for the patient to bring suit against the physician for alleged failure to use reasonable care and that action is usually in tort. In effect, therefore, the medical practitioner stands to pay compensation at anytime he acts below the standard required of a competent practitioner of his class, experience and circumstance[3]. This standard is not constant, it is dynamic and changes in accordance with the area of specialization of each doctor. Differences in circumstances and facilities at the place of work may also affect the standard required in each case thus, a more efficient medical services may be expected in a modern well-equipped hospital than a village medical center.

For liability to arise under this head, the alleged negligence has to be proven. And the quantum of proof is a preponderance of probability. The plaintiff has to adduce evidence to show that the medical practitioner was negligent. Generally, in medical malpractice cases, it may be difficult for the patient plaintiff to prove negligence because he may not know what happened. In view of this difficulty of direct proof of fault and of the causal nexus between the fault and injury, the court may allow the plaintiff to rely on the doctrine of Res Ipsa loquitur[4]. What this implies is that the burden of proof will be shifted from the plaintiff to the defendant.

5.1.2. **Trespass And Criminal Liability of Medical Practitioners.**

5.1.2.1. Trespass in this area of the law refers to trespass to the person, precisely assault and battery. Trespass to the person means direct and forcible interference with the person of another, without consent express or implied At Common Law, any medical practitioner who treats or carries out any professional activity on a patient without his consent express or implied, such an act can give rise to a cause of action in battery and /or assault. Consent is therefore central to the idea of medical practice and to the doctor - patient relationship and in determining the liability of medical practitioners in battery and assault.

The physician has no right to examine or treat a patient without his consent. The consent that is in issue here, is not the consent as a constitutive element for the conclusion of the contract with the medical practitioner but consent as a condition precedent to and justification for the legality of the physician's intervention. This principle applies in Nigeria as well as other

countries with variations in its technical formulation. This rule is subject to the exception that in an emergency if it is impossible or impracticable to obtain the patients consent or the consent of anyone authorized to assume such responsibility, in which case, the law implies consent[5]. In conformity therefore with medico-legal ethics[6], the medical practitioner is under an obligation to treat without consent, especially when the patient's condition is such as to imperil his life. Although the Physician has no right to take action by force or by misleading the patient.

The Nature of the consent required to satisfy the requirement of medico-legal ethics is informed consent. Informed consent simply means that a patient who is matured and who is able to take decisions based on sound reasoning must be fully and sufficiently informed about the purpose, nature and the implications of the medical treatment to be administered on him, including the risk involved, so that he may choose whether to go in for it or not. For consent to be valid, the person who gave the consent must have had the requisite capacity to do so, the consent must have been given based on knowledge of what is to be done and the repercussion, and finally if an operation or treatment entirely different from that contemplated becomes necessary, the need, for fresh consent will arise.

Failure to obtain valid consent, any unauthorized treatment or operation, will give rise to an action in assault, battery and crime.

5.1.3. Defences and Remedies For Medical Practitioners Liability.

5.1.3.1. **Defences**

In Medical Professional Liability Suits, the burden of proving medical liability of the medical practitioner rests upon the patient[8]. This means that the evidence presented by the patient must be more convincing than that presented by the physician. The physician is presumed to be free from liability until the contrary is proved. The patient must sustain the burden of proof with respect to the essential allegations of his claim against the medical practitioner. If he charges the practitioner with professional negligence, for example, he has the burden of establishing the standard of care applicable to the physician, and of proving the practitioner's failure to conform to that standard of care[9]. Secondly, if the patient alleges technical assault and battery by alleging that the doctor operated on him or treated him without his consent, then he has to prove that he did not consent and that the circumstances did not call for emergency treatment[10]. Even where the patient plaintiff has discharged himself of the necessary burden of proof, the medical practitioner may still not be liable in medical mishap if it can be shown and successfully pleaded that the medical practitioner has a defence to his act. Some of these defences are contributory negligence, voluntary assumption of risk, statute of limitation and special defences for the injuries sustained and in order to arrive at the amount and the nature of damages that the plaintiff-patient is entitled to, it is necessary to know whether the damages are for personal injuries or for death.

Damages are the pecuniary or monetary compensation that may be recovered in a law suit for breach of some duty or the violation of some right recognized by the law[11].

5.2. **Recommendation.**

1. It was found in chapter two that in Nigeria there are rampant cases of poor diagnosis, leading to death and aggravation of illnesses, but the victims hardly realize them and even when they do realize them they no not litigate. This is so because most patients are poor and cannot cope with the heavy cost of litigation and other especially the Muslims from the Northern part who believe that every mishap is as a result of the will of God, which no human being can stand to challenge. It is recommended that victims of medical negligence should always go to court to vindicate their rights if they have the means to pay legal cost. Or they could approach the Legal Aid Council and Other; Non-Governmental Associations such as Network for Justice, among others; for legal assistance especially the poor victims. This will shape the conduct of the unruly health care deliverers.

2. It was also observed in chapter two that even when some victims of medical mishap file their suits, they end up failing in the courts because of failure to conduct post-mortem examination. It is therefore recommended that the plaintiffs should always seek for post-Mortem to be conducted, or proper tests must be ordered to be conducted to categorically ascertain the causes of the injuries or death. This will reduce the cost of litigation, expedite cases in court and also enhance the successes of the complainants.

3. It is recommended that hospital managements should organize short training courses in law of torts, to educate medical practitioners on the legal responsibilities towards their patients. This will minimize malpractice suits and their attendant huge financial costs and redeem the image of the health care providers.

4. It is also recommended that where an employee performs his duties recklessly, leading to damages, the employers should also ensure that appropriate disciplinary measures are taken against them. From the findings in our questionnaire, the issue of drug mal-administraticn is a common phenomenon amongst medical practitioners in Nigeria. It is therefore recommended that, in order to curb such a malpractice, professional bodies should have an input, with a view to taking disciplinary actions gainst professionals who exhibit or are found to have exhibited such unpardonable levels of in-discipline and negligence.

5. It has been observed in Chapter two that, injuries arising from x-rays therapy are common in Nigeria, but because of ignorance and illiteracy, victims hardly notice the injuries and even when they do, they hardly have the means to consult specialists to ascertain the cause. Awareness programmes are therefore recommended in order to educate potential patients of x-ray therapy on their rights.

6. It was also observed in Chapter two that surgical mishap is a common phenomenon of medical negligence in Nigeria, leading to numerous surgical deaths. Investigation from Questionnaires has revealed that a wide range of

problems including poor or absent documentation, deficiency in essential services, surgeons operating outside their specialty and the use of poorly-trained and supervised locum are causes of surgical deaths. It is therefore recommended that hospital managements should improve on the available surgical facilities, obtain modern surgical instruments, employ well-trained staff and specialists and retrain them periodically, in order to enhance efficiency and minimize the rate of surgical mishaps.

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

8. It was observed in Chapter three that it is mandatory for any medical practitioner to disclosed all facts relating to an operation or treatment to a patient in order to enable the patient give a valid consent. It is submitted that a reasonable man would hesitate to undergo or undertake hazardous treatment and therefore, unless therapeutic reasons contra-indicate, doctors are advised to always make simple, quiet but honest disclosure commensurate with the risks in all cases and let the patients those what risk or risks to run with their bodies. Where, for therapeutic reasons, it is medically and legally unethical to inform the patient of the risks or dangers involved in the treatment or operation, a responsible relative of the patient should be informed on the patient's behalf and obtain his or her informed consent. Besides informing the patient or his

responsible relation of the risks or hazards involved in an operation or treatment, it should always be insisted that a consent in writing in which the patient or someone else on his behalf acknowledges this explanation. This will reduce malpractice suits.

9. It was observed in chapter four that there is striking absence of Nigerian cases on the defence of voluntary assumption of risk because of the following reasons:

Firstly high illiteracy level, especially in the Northern part of Nigeria makes patients to be ignorant of their rights to sue when medical malpractice is committed on them.

Secondly, religious belief and poverty have also militated against the patients desire to bring actions against medical practitioners for medical mishaps. The population should, therefore, through the mass media, churches and mosques be educated that it is a religious, social and legal right to sue for medical mishap. The government should also allocate funds to the Legal Aid Councils to assist victims of medical mishaps who because of poverty cannot initiate legal proceedings to vindicate their rights against negligent medical practitioners.

10. It was observe is chapter four that any professional mishap on the part of the medical practitioner may give rise to very colossal financial consequence. The cost implication may have a negative effect on the volume of medical practice likely to be carried out. This will have a negative effect on the supply of medical practitioners. In view of the fact that the ratio of doctor-patient is very

low compared to our contemporary need, it is recommended that medical practitioner should be very careful in handling the treatment and operation of patients and also take up third-party insurance policy. This will reduce their costs of medical practice in the event of a likely professional mishap.

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4. John Cooke Op. Cit. P. 161.
5. Crawford Morris R. And Alan R. Moritz, Op. 147
6. See French Decree No. 55-1591 of 28th November, 1955.
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10. See State to the use of Janney v. Housekeeper 7 Md. 162, 16A(1889)
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