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Medical Negligence and Its Litigation in Nigeria

Babafemi Odunsi[1,2*]

[1]Faculty of Law, Obafemi Awolowo University, Ile-Ife, Nigeria
[2]Faculty of Law, Olabisi Onabanjo University, Ago-Iwoye, Nigeria
Email: babafemiodunsi@yahoo.com

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Abstract

With Nigeria as focus, and adopting a doctrinal legal research approach, this paper engages the incidence of medical negligence along with the processes of pursuing redress through litigation and allied modes. The paper adopts pertinent primary judicial and legal authorities along with Common Law rules in the discourse of the medical negligence; these are supported, as necessary, with secondary authorities, such as opinions of learned writers, as expounded in texts, articles and other media. In related vein, the paper discusses the likely modes by which persons, directly or indirectly, affected by medical negligence can pursue redress. In a sociological context, the paper notes the relatively lower rates of litigations on medical negligence in Nigeria, compared with the situations in developed countries like the United States of America and Britain; the paper highlights the diverse social, religious and cultural factors that have made many aggrieved persons shy away from litigation in cases of medical negligence. The paper reflects that the influence of globalisation and social media, which increased rights-consciousness among Nigerians, has the possibility of increase in medical negligence litigations in the country. More so, the issue of medical litigation has been attracting the attention of medical practitioners, judicial officers, legal practitioners and other stakeholders in Nigeria. All these justify a fresh look at medical negligence, as undertaken in this paper. In its conclusive part, the paper flags the need for proactiveness and circumspectness in sanctioning medical doctors for medical negligence; this is to avoid a situation in which would eagerly resort to self-preservation mindset of "better not to get involved" for the purpose of avoiding stressful litigations flowing form their striving to be "good Samaritans".

*The author is also a MacArthur Fellow (Reproductive and Sexual Health Law), Faculty of Law, University of Toronto, Toronto, Canada. Formerly, the author was a Research Associate, AIDS and Human Rights Research Unit, (Centre for Human Rights and Centre for the Study of AIDS) Faculty of Law, University of Pretoria, Pretoria, South Africa; also, he was a Research Associate, Faculty of Law, University of the Free State, Bloemfontein, South Africa.

Keywords

Negligence, Medical Negligence, Doctors, Codes of Ethics, *Res Ipsa Loquitor*, Criminal Law

1. Introduction

Going by the Judeo-Christian cosmogony or the Biblical account of creation, as more popularly known, human life or world began in the Garden of Eden (Holy Bible-Reference Edition, 2010). Along that axis, it can be said that medical practice, literally, started from the beginning of the world in Eden; this was in the creation of Eve as wife and companion for Adam, the first human. The Bible (Holy Bible-Reference Edition, 2010) in Genesis chapter 2, verses 18, 21 - 23 gives account of Eve's creation as follows:

> 18—And the LORD God said, *it is* not good that the man should be alone; I will make him a help meet for him...
> 21—And the LORD God caused a deep sleep to fall upon Adam, and he slept: and he took one of his ribs, and closed up the flesh instead thereof;
> 22—And the rib, which the LORD GOD had taken from man, made he a woman, and brought her unto the man.
> 23—And Adam said, this is now bone of my bones, and flesh of my flesh: she shall be called Woman, because she was taken out of Man.

In outlook, the process of Eve's creation reflects the contemporary procedures of invasive medical surgery and biomedical human cloning. The causing of Adam to sound sleep would equate to the conventional medical practice of anesthetizing patients to avert pain and discomforts in the performance of invasive surgery. The aspect of [opening] the side of Adam, extracting his rib, and thereafter closing up the flesh, reflects the practice and procedure of contemporary medical surgery itself. The transformation of Adam's extracted bone into the human person of Eve, in perspective, has semblance of non-therapeutic or reproductive human cloning, as presented in some works (National Human Genome Research Institute [Bethesda, USA], 2020; Castro, 2011) which has largely been an emotive issue, in terms of religion, medical ethics, and law.

Manifestly, as the process of creating Eve in the Garden of Eden was undertaken by an all-knowing and infallible God, the question of any medical error, negligence or any other form of mishap did not arise in the scenario. Subsequently, due to their rebellion in conspiracy with the Serpent, Adam and Eve lost occupancy and residency of Eden (Holy Bible-Reference Edition, 2010). Thereafter, day-to-day activities of humans in the worldly realm, including medical practice, progressively became the affairs of humans. With the inherent imperfection of human, the issues of medical errors through negligence and other factors became components of human living, with attendant need to adopt legal

and related devices to redress or deter such occurrences over the ages.

In respect of human medical practice, the *Code of Hammurabi*, promulgated by King Hammurabi of ancient Babylon, (Holmes, 1905) offers an insight into the desperate efforts and measures which humans and societies have adopted in regulating medical practice and confronting harmful medical wrongdoings over times. *Inter alia*, at a general level applicable to all citizens, doctors inclusive, the *Code of Hammurabi* provided:

> If a man destroys the eye of another man, they shall destroy his eye. If one breaks a man's bone, they shall break his bone. If one destroys the eye of a freeman or breaks the bone of a freeman he shall pay one gold mina. If one destroys the eye of a man's slave or breaks a bone of a man's slave he shall pay one-half his price (Prince, 1904; Ancient Pages, 2016).

In the more specific context of medical practice, the *Code of Hammurabi* provided:

> If a surgeon performs a major operation on an "awelum" (nobleman), with a lancet and caused the death of this man, they shall cut off his [doctor/surgeon's] hands (Mitchel & Riley, 2014; Spiegel, 1997)... If a physician operates on the slave of a freeman for a severe wound with a bronze lancet and causes his death, he shall restore a slave of equal value. If he opens an abscess in his eye with a bronze lancet, and destroys his eye, he shall pay silver to the extent of one-half his price... (Spiegel, 1997).

Over time, less drastic and brutal measures, in form of regulatory ethical codes for medical practice, began to emerge in safeguarding the interest of patients. Prominent in this respect was the historical *Hippocratic Oath*, as contemporarily provide (Mason, McCall Smith, & Laurie, 2002). The *Hippocratic* Oath, as a global code of medical practice, *inter alia*, prescribed generally that a doctor must act for the *good* of his patient. This prescription has also been integrated in contemporary medical ethical guidelines as adopted or formulated at different times (*Declaration of Geneva* (As amended at Stockholm, 1994); *International Code of Medical Ethics* (As amended at Venice, 1983)).

Who determines what is *good* between the doctor and his patient, or the patient's proxies, has been an issue of touchy discourse and subject of litigations over times (*Re SL* (*Adult Patient*) (*Medical Treatment*), 2000). At some point, the regulation of medical practice by law in addition to self-regulatory ethical prescriptions became entrenched, despite divergence of opinions on the issue (Mason, McCall Smith, & Laurie, 2002). With the intervention of Law in medical practice, diverse forms of legislation, regulations and policies evolved at different times in further control of the practice of medicine for the benefit of the society. It is in the framework of the legal intervention in medical practice that *Medical Negligence*, as a cause or ground for legal action, was spawned.

Medical negligence, as a ground or cause of action can touch on the performance of a diversity of healthcare providers such as nurses, pharmacists, anaesthe-

tists, laboratory technologists, physiotherapists and so on (Odunsi, 2008). By extension, it can also vicariously affect the employers of caregivers, as is usually the case. However, by way of delineation of scope, medical doctors would be adopted as focus of discussion in this paper. The principal reason for this is that it would be unwieldy to discuss medical negligence as applicable to all direct and indirect healthcare professionals in the scope of this paper. Furthermore, doctors, by and large, occupy key position and play central role in the conventional healthcare setting, with other providers offering supporting services for doctors as the coordinating pilots. Perhaps, it is necessary to state that this assertion is not in any way intended to insinuate the professional superiority of doctors in healthcare setting or the subservience of other healthcare professionals to doctors. Also, medical negligence jurisprudence, particularly in terms of case law arising from litigations over the years, has preponderantly involved doctors; thus without expressly serialising the diverse genres of healthcare professionals, the jurisprudence and legal principles applicable to doctors, *mutatis mutandis*, can be related to other healthcare professionals.

2. Regulation of Medical Practice in Contemporary Times: An Overview

It is trite that, in the present times in Nigeria and beyond, medical practice, in its different ramifications, is regulated by an interworking web of laws, rules and policies (*Medical and Dental Practitioners* Act, 2004; Criminal *Code Act*, 2004; *National Health Act*, 2014; *Compulsory Treatment and Care for Victims of Gunshot Act*, 2017; *Rules of Professional Conduct for Medical and Dental Practitioners*; Violato, 2013). In addition to the legal frameworks, there are supporting institutional structures overseeing medical practice (Violato, 2013).

As a component of the contemporary legal and related regulation of medical practice, it is now required that doctors in Nigeria and other places should have university education and training with academic medical Degrees from their training institutions (*Medical and Dental Practitioners* Act, 2004; Violato, 2013). In addition to the university education and training or acquisition of medical Degrees, prospective doctors would further undergo post-university supervised clinical training or *residency* (*Medical and Dental Practitioners* Act, 2004). Once a doctor has passed all relevant examinations, and satisfies other prescribed procedures, the doctor can acquire a licence to engage in medical practice without direct supervision, and be deemed to have the required competence to practise medicine Nigeria (*Medical and Dental Practitioners* Act, 2004). In advancing beyond primary levels of professional medical qualification, doctors usually go for postgraduate qualifications at sub-regional and other levels, such as acquiring the Fellowship of West African College of Physicians to advance to the level of *Consultants* in Nigeria.

As a corollary to the academic and professional trainings of doctors at national levels, doctors who have earned their degrees and qualifications in other

jurisdictions need to adhere to the pertinent regulations for practising in another jurisdiction, such as licensing or certification, before they can practise medicine therein (*Medical and Dental Practitioners* Act, 2004; Violato, 2013). This regimentation of re-assessing doctors from other jurisdictions or re-licensing them to practice in new jurisdictions has been of long historical origin. This can be illustrated by the 14th century story of Leonardo Fioravanti, a doctor with degree from the University of Bologna, a preeminent medical school at that time (Violato, 2013).

Fioravanti was arrested and imprisoned by officers of Milan Public Health Board for practising medicine in the city, another jurisdiction different from Bologna, where he was primarily licensed to practise. The charge against him was that he was not medicating in the accepted way. For some time, doctors in Milan had held grudge and plotting against him since his arrival from Venice in 1572. They regarded him an outsider, an alien and an unwelcome Bolognese intruder in the jurisdictional scope of Milanese medical practice. He wrote a letter of protest challenging his arrest and incarceration to the health minister who was then responsible for the regulation of medical practice and related issues in Milan.

It is necessary to highlight that Fioravanti was not a medical charlatan, quack or scam. He was not even a run-of-the-mill barber-surgeon. He had practiced medicine for years in Bologna, Rome, Sicily, Venice and Spain. He had a MD from the University of Bologna, had published several medical texts, had developed many medicines, and was a severe critic of much of conventional medical practice. Notwithstanding, "the *Milan physicians were not welcoming and considered him a foreign doctor*." (Violato, 2013). Ultimately, it took the intervention of the Health Minister, Boldoni, and a Milan court to set Fioravanti free.

3. Contemporary Medical Regulations: Persistence of Medical Errors and Harms to Patients

To recap, diverse legal, regulatory and related measures had been adopted from the time of Hammurabi to contemporary times to safeguard the interests of patients and society against medical harms. However, it would appear that these measures have not had the desired results. One study and report in the United States of America, one of the most advanced countries in the world, lent credence to the situation in the contemporary times.

In 1999, the American Institute of Medicine of the National Academy of Science released a report, *To Err Is Human*: *Building a Safer Health System*. The report showed that nearly 100,000 people in hospitals died annually in the United States as a result of medical mistakes. It has been contended that the statistics was an underestimate and the actual mortality rate could be much higher (Violato, 2013). The claims triggered international discussions, concerns and controversies about patients' injuries in the course of healthcare. The cases were considered to include errors due to drug overdoses or interactions, misdiagno-

ses, botched surgeries, incorrect medications, and simple carelessness. Patient safety, a topic that had been little understood, and even less discussed in health-care systems, thus became a public concern in most Western countries (Olofinlua, 2015 [Part 1]).

Generally, in contemporary medical practice, wholesome patient safety has not been satisfactorily achieved with thousands, and possibly, millions of patients being injured or dying from medical errors across the world (Violato, 2013). Doctors, particularly, have been called upon to address the underlying causes of medical error and harm. How well doctors have embraced and addressed the concerns remains debatable; for example, as Claudio Violato noted, "several studies have shown that even by 2007 more than half of hospital doctors surveyed had not even heard of the report, *To Err Is Human"* which, as earlier noted, in a significant way, contributed to robust international discussions and concerns on the issues of patients' safety and medical errors (Violato, 2013).

It has been noted,

> It is not surprising then that few advances have been made in reducing medical errors and increasing patient safety in the past decade. A recent study of 464 major adult cardiac surgical cases at three hospitals resulted in 1,627 reports of problems and errors for an average of 3.5 and maximum of 26 per procedure. Nearly three-fourths of the cases (73.3%) had at least one recorded event. One-third (33.3%) of events occurred prior to the first incision, and 31.2% of events occurred while on bypass. About two-thirds (68.0%) of events were considered as minor in severity (e.g., delays and missing equipment), but a frightening percentage (32.0%) was considered major and included anastomotic problems (e.g., suturing vessels), pump failure, and drug errors. Many (30.9%) of the problems were never even discussed among the surgical team. A wide range of problems and errors occurs during the majority of cardiac surgery procedures. Cynics argue that the number of medical mistakes is much higher than is commonly accepted because most of the errors are buried with the patient (Violato, 2013).

In a similar vein, another source, with a comparative reference to Nigeria, has noted,

> A study in the current issue of the Journal of Patient Safety suggests that each year between 210,000 and 440,000 American patients who go to the hospital for care suffer some type of preventable harm that contributes to their death, making medical errors the third-leading cause of death in America after heart disease and cancer. If America suffers from this degree of medical negligence, even with its more highly developed and sophisticated health care system, then it follows that Nigeria, with its weaker health care infrastructure and under reporting of medical negligence cases, is even worse off. And while there is no incontrovertible data on the actual number of medical negligence cases in Nigerian hospitals, patients and medical

practitioners alike acknowledge that number to be very high (Olofinlua, 2015 [Part 1]).

In Nigeria, in support of the long standing *Medical and Dental Practitioners Act*, Code of Medical Ethics and related provisions, some proactive measures have been introduced at different times to sanctify the realms of medical practice. As an example, the *National Health Insurance Scheme Act*, 1999 presents some noteworthy provisions (Obalum & Fiberesima, 2012). The Scheme, among others, prescribes that Health Maintenance Organisations (HMOs) undertake periodic monitoring and evaluation of healthcare providers as well as organising regular seminars for them. Furthermore, HMOs are to ensure the provision of monthly statistical returns on healthcare providers' performances at different healthcare institutions and facilities registered with the scheme. The components of the statistical returns are to include the rate of patient attendance, investigations, admissions, and disease patterns (Iyioha, 2015). "These provisions are designed to ensure the maintenance of 'a functional healthcare system, maintaining professional standards at the different facilities and reducing the incidence of systemic error'" (Iyioha, 2015). Mention can also be made of Service Compact with All Nigerians (SERVICOM) which relates to ensuring wholesome performances among those engaged in delivering public services, including public healthcare providers (Odunsi, 2010). How far these measures have gone in improving patients' safety and untainted medical practices, in the absence of statistical or empirical evaluations, remains debatable. More so, when there have continued to be series of accounts of untoward incidents emanating from the realms of medical treatment in different dimensions in the face of the extant legal and proactive measures (Olofinlua, 2015 [Part 1]; Olofinlua, 2015 [Part 2]; Owoseye, 2018).

Unwholesome medical errors have been attributed to doctor's carelessness, ignorance, lack of professionalism, sleeplessness and exhaustion, physician arrogance, laziness, and poor self-assessment, particularly of personal limitations in medical skills and so on (Violato, 2013). In some context, these factors are conventionally regarded as *challenges* of healthcare systems. This perception, perhaps, would have some attraction in the case of Nigeria which has for long had problematic healthcare system and service delivery due to uninspiring medical equipment and facilities, along with other factors; a health care system in which government officials as providers, operators and overseers do not even have confidence, going by their tendencies to customarily travel to other countries for medical attentions (Odunsi, 2015; Odunsi & Raimi, 2016; Odunsi, 2010). The tendency to attribute medical errors to systemic challenges may have an effect of shifting attention and the discourse away from doctors' individual accountability for errors. A tendency to blame systems rather than individual doctors can affect the drive to hold individual doctors responsible for medical errors under the camouflage of system challenges.

Quite true, in some respects, systemic problems in terms of lack of appropri-

ate equipment and facilities, overwork due to inadequate well-trained personnel, motivation of available personnel and so on can affect the performances of doctors. Nonetheless, this cannot overshadow the aspect of doctors' performance. After all, in assessment of medical negligence, the performance of a doctor can be considered in relation to the standard of his locality *vis-a-vis* available equipment, facilities, circumstances of performing a medical task and extant benchmarks. Put simply, how well a doctor has undertaken a medical task can be measured in the context of the circumstances in which he performs the task. Hence, a doctor in a situation faced with challenges of equipment and facility, such as Nigeria, should not be summarily excused on the ground of systemic challenges that he does not have the advantage of equipment and facilities available in more advanced countries. Similarly, a doctor performing a task in a rural medical as facility cannot be excused on the ground of not having equipment available in urban, better equipped areas. Thus, system challenges should not be an escape route for doctors' unwholesome acts in medical practice. It is in the structure of the foregoing analysis that the accountability of doctors for medical negligence is entrenched in legal and judicial discourse.

4. Medical Negligence in Legal Perspective

The tort of *Negligence*, in the generic sense, is the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs, would do or doing something which a prudent and reasonable man would not do (*Blyth v. Birmingham Waterworks*, 1856). It is not for every careless act that a man may be held liable in negligence as the tort relates to a breach of legal duty of care to the person to whom the defendant holds the duty and which results in legal injury.

Thus, for a claimant to make a case of negligence in law, the following elements must be established:

1) That the defendant owes the claimant a legal duty of care in the context in question.

2) That the defendant has been in breach of that duty.

3) That consequential to the defendant's breach of the duty of care, the claimant has suffered harm or loss which flow from, or are caused by the breach of duty of care and not too remote from the causation/breach of duty of care.

It is trite that failure to appropriately establish any of these basic legal elements would be fatal in establishing liability for negligence against the defendant.

Contextually, medical negligence is an offshoot or genre of the generic tort of negligence with the basic elements being applicable. Thus, medical negligence occurs in a situation where a doctor, owing a duty of care to the patient breaches that duty and the patient suffers injury. A central component is that the doctor acts in a negligent and injurious manner, in which a reasonable doctor in the affected doctor's professional standing and circumstances, would not have acted

or expected to have acted.

Various acts or omissions can amount to grounds for medical negligence and causes of action. These include: (Iyioha 2015, Kuteyi, 2016, Obafemi, 2017).

A) Failure to attend promptly to a patient requiring urgent attention when the doctor was in a position to do so.

B) Improper or incompetent assessment of a patient, or incorrect diagnosis, particularly when the clinical features were so glaring that no reasonable and competent doctor could have failed to notice them.

C) Failure to advise, or proffering wrong advice, to a patient on the risk involved in a particular operation or course of treatment, especially if such an operation or course of treatment is likely to result in serious side effects or harms.

D) Failure to obtain the consent of the patient (informed or otherwise) before proceeding on any surgical procedure or course of treatment, when such consent was necessary.

E) Unjustifiable error in treatment e.g., amputation of the wrong limb, inadvertent termination of a pregnancy, prescribing the wrong drug in error for a correctly diagnosed ailment, and so on.

F) Failure to refer or transfer a patient in good time when such a referral or transfer was necessary.

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

H) Failure to see a patient as often as his medical condition warrants or to make proper notes of the practitioner's observations and prescribed treatment during such visits or to communicate with the patient or his relation as may be necessary with regards to any developments, progress or prognosis in the patient's condition.

I) Failure to admit into hospital a patient whose condition requires hospitalisation.

J) Leaving a surgical instrument or swab in the body of a patient after operation.

K) Failure to cross match blood before transfusion.

L) Using a patient for experimental purposes without his consent.

M) Use of unsterilized tools.

N) Where swab is left in operation site or patient wakes up in the course of surgical operation despite general anaesthetic).

O) Unjustifiable infringement on any of the rights of the patient in the course of treatment, e.g., undertaking a line of treatment that is against the religion of a patient and the will of the patient.

5. Legal Actions on Medical Negligence

Generally, as in other areas of law, it is a patient who is aggrieved by medical negligence that can initiate legal processes for redress or sanctioning of offending doctor. However, where the patient is a minor, the proxy or surrogate of the child, such as parent or legal guardian, can initiate complaint processes on the

minor's behalf as next friend (*Esabunor & Another v Faweya & Ors*, 2019); same would operate where the patient lacks competence on the basis of any mental incapacitations. Where the negligent act results in death, any competent survivor or successor of the deceased can initiate action in respect of the "wrongful death" of the victim (*Tarassoff v Regents of the University of California*, 1976; *Raimi Jenyo and F. A. Aderemi* (*Administrators of the Estate of Basiratu Raimi* (*Deceased*)) *v Akinsanmi Akinreti and Anor.*, 1990; *Aderinola Adeyemi and Ors. v Shittu Bamidele and Anor.*, 1968; *Fatal Accidents Law* of Lagos State, 1961). The processes initiated can be against the doctor individually, or by vicariously joining the master or employer of the doctor in appropriate situations (Iyioha, 2015).

Whether directly by an aggrieved patient, or any of the qualified proxies, legal processes that can be initiated against a doctor can either be civil or criminal in nature. Criminal action would arise where the negligent act complained of amounts to a *gross* or *criminal* negligence as operative under pertinent laws (*Nigerian Criminal Code*—Sections 303 & 305). In essence, an act of medical negligence can generate both civil and criminal actions. In initiating civil and criminal actions for medical negligence, an aggrieved patient or proxy may adopt any of the following options or steps directly or through a legal practitioner:

1) Writing a letter of complaint and demand for redress to the doctor or his employer on the incident of medical negligence.

Whether or not (1.) above is first adopted?

2) A formal complaint can be filed with the Medical and Dental Council of Nigeria for appropriate redress (*Medical and Dental Practitioners Act*—sections 1, 3, 15 & 16).

3) Making a report at a Police Station with an ultimate desire of criminal prosecution where the negligent act in question is perceived to be criminal. This is more likely to occur in situations of death or grievous bodily injuries to the patient through the doctor's act (Iyioha, 2015).

4) Instituting civil action for redress in a court of appropriate jurisdiction on the ground of the act or conduct constitution medical negligence. Such civil actions can proceed from the court of primary jurisdiction to the final court of appeal, as in civil actions on other subjects other than medical negligence (Iyioha, 2015).

In the cases of 2 and 3 above, the trial is between the Council, and the Prosecutor at appropriate courts, respectively with the affected doctor as defendant. The aggrieved patient essentially stands as witness and complainant on whose behalf the Council or government prosecutor pursue sanctions. In the case of 4, the battle is directly between the aggrieved patient and the doctor in the conventional setting of Plaintiff/Claimant versus Defendant, with each side striving to prove his case as prescribed by law. In any situation of contest, the culpability of the doctor for the alleged negligent act must be established by the prosecutors or claimants; otherwise, there would be no basis for sanctions or redress. Perhaps, it

bears adding too, that all the necessary principles for fair-hearing and due process must be adhered to; if not a doctor sanctioned at a lower forum may walk free at an appellate forum (*Medical and Dental Practitioners Disciplinary Tribunal v* Okonkwo, 2002).

5.1. Medical Negligence: Option of a Non-Adversarial Approach

The options listed above, particularly 2 - 4, fall within the *adversarial system* framework of litigation in the Nigerian legal system.

The *National Health Insurance Scheme Act*, 1999, now *National Health Insurance Authority Act* (NHIA), 2022 in outlook, seemed to offer an avenue for a non-adversarial option to resolve medical negligence disputes. In one respect, Health Management Organisations (HMOs) were required to provide complaint boxes at their facilities for the reporting of grievances about services offered. In another vein, the Scheme further created arbitration boards for the resolution of medical negligence disputes; the arbitration boards and alternative dispute resolution (ADR) outlets offer options for patients to seek relief outside the conventional adversarial structure, such as court actions (Iyioha, 2015). An advantage embedded in the ADR approaches is that doctors and patients may be more comfortable negotiating the compensation to be paid to victims of medical negligence (Iyioha, 2015).

Without prejudice to the option of the non-adversarial approach, the preponderant focus of this paper is on the adversarial civil litigations as means of seeking redress for medical negligence. However, before delving into the aspect of civil litigations, it is considered pertinent to discuss briefly the criminal law aspect of medical negligence.

5.2. Criminal Law Perspective of Medical Negligence

Generally, except in cases of wilful acts of homicide or assisted suicide services rendered to a patient, (Nigerian *Criminal Code*—section, 326) it is unlikely that a doctor would be charged for murder or culpable homicide where a medical negligence results in death of the patient. This can be attributed to the absence of *mens rea* for culpable homicide in the circumstances. Moreover, section 24 of the *Criminal Code* exculpates an individual from criminal guilt where an alleged crime is due to accident.

However, a doctor can face criminal sanction for manslaughter or culpable homicide not punishable with death if his conduct is found to translate to gross or criminal negligence. Along this axis, section 303 of the *Criminal Code* provides:

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

any person by reason of any omission to observe or perform that duty.

Where a doctor faces criminal trial for manslaughter due to gross medical negligence the trial follows all pertinent processes, procedures and rules of criminal trials. The doctor-defendant, in addition to all possible basic defences, such as prosecutor's failure to establish guilt beyond reasonable doubt, can invoke sections 297 and 313 of the *Criminal Code*.

5.3. Civil Litigation on Medical Negligence—Establishment of Claims

Largely, action for medical negligence falls under the Law of Tort. In some cases, however, an action for medical negligence may arise under Law of Contract. In a matter arising under contract, the essence is that doctor has not acted reasonably in displaying competent skill or achieving desired result, as agreed with the patient (*Henebery v Pharoan*, 2017). Generally, to sustain a medical negligence case on contract the plaintiff must show that the doctor has made an additional promise or warranty, beyond the inherent agreement or expectation in doctor-patient relationship, that doctors would exercise reasonable care and skill (*Henebery v Pharoan*, 2017).

In medical negligence actions under tort or contract, the patient has a legal duty, or burden of proof, to establish his allegation of negligence and entitlement to redress against the doctor. This burden of proof is to be discharged on the balance of probabilities or preponderance of evidence (*Evidence Act*, 2011 section 134). Put differently, it is up to the plaintiff to prove the allegations of negligence and his entitlement to redress.

The mode of proving or establishing a medical negligence case is set in some definite legal framework; this, essentially, entails the contending parties calling witnesses to adduce relevant evidence in respect of their positions. The need for medical expert witness is particularly crucial in medical negligence cases. Absence of required expert evidence can be fatal to the case of any of the parties that fails to invoke such evidence where necessary. A scholar, Obafemi, puts this situation thus:

> It is a sad commentary on the lack of sophistication of the Plaintiffs' Bar in Nigeria and other common law jurisdictions that medical negligence claims are frequently launched and advanced at trial without expert medical evidence. The plaintiff comes to court and gives his or her account of what occurred but fails to back up allegations of negligence with coherent evidence from a medical expert. In such circumstances, it is no surprise that courts will heed the exculpatory evidence inevitably provided by experts on behalf of the defendant and dismiss the claim (Obafemi, 2017).

Further, the writer reflects:

> Why should it be that claims are advanced without medical expert witnesses? Incompetence on the part of the plaintiff's counsel cannot be ruled

> out. One should not discount resource challenges, however: medical experts can be very expensive and beyond the means of impoverished plaintiffs. Moreover, it may be hard to find a doctor willing to give evidence criticising the conduct of another doctor (Obafemi, 2017).

Even where the plaintiff/claimant presents a medical witness to give expert evidence, the reality is that the defendant can produce a counter expert witness to challenge the expert evidence of the patient-plaintiff. The foregoing connotes that in presentation of witnesses or adducing evidence, a party aiming to prevail needs to ensure that he presents expert or non-expert evidence that would enjoy higher credibility or higher probative value with the court. Thus, where the contending parties present opposing witnesses or evidence on an issue, the position of the more impressive witness will prevail. Thus, in the case of *Unilorin Teaching Hospital v Abegunde*, 2015, the Court of Appeal (Ilorin Division) found more impressive and preferable the expert evidence of the defendant's witness, a Consultant Surgeon, than the evidence offered by the plaintiff's witness, a resident doctor. A learned Justice of the court, Ogbuinya JCA noted, "[b]eing an expert witness, the law gives me the licence to crown his [the Consultant Surgeon's] evidence with the toga of high probative value. On this score, the evidence of [the Consultant Surgeon's] make mincemeat of those of [plaintiff's witness] in all aspects they were on collision course" (*Unilorin Teaching Hospital v Abegunde*, 2015).

Apart from adducing direct expert or non-expert evidence, a plaintiff-patient can seek to prove a case of medical negligence by the indirect or circumstantial evidence mode of *res ipsa loquitor*. From a perspective of legal history, the injection of *res ipsa loquitor* into judicial parlance can be traced to the case of *Byrne v Boadle*, 1863. In the case, a barrel fell from the defendant's premises injuring the plaintiff on the road below. What exactly precipitated the accident was not known to the plaintiff. The Defendant's counsel had sought a dismissal of the plaintiff's case on the ground that there was no evidence of negligence. Addressing the contention of the Defendant's Counsel, Pollock CB responded: "there are certain cases of which it may be said *res ipsa loquitur* and this seems one of them…" (*Byrne v* Boadle, 1863).

An expatiation of the characteristics and principles of *res ipsa loquitor* was proffered in the latter case of *Scott v London & St. Katherine Docks Co.*, 1865. The plaintiff, a customs officer, in the course of performing his duty passed in front of the defendant's warehouse where six bags of sugar fell on him. Pronouncing on the basis for inferring negligence for the purposes of liability, Erle CJ stated:

> There must be reasonable evidence of negligence. But where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary circumstances does not happen if those who have the management use proper care, it affords reasonable evi-

dence, in the absence of explanation by the defendants, that the accident arose from want of care (*Scott v London & St. Katherine Docks Co*, 1865).

In the case of *Plateau State Health Services Management Board & Anor v Philip Fitoka Goshwe*, 2012, referring to the case of *Royal Ade Nigeria Ltd. & Anor. v National Oil and Chemical Marketing Company Plc.*, 2004, the Nigerian Supreme Court set out the circumstances under which *res ipsa loquitur* would operate as follows:

1) Proof of the happening of an unexplained occurrence.

2) The occurrence must be one which would not have happened in the ordinary course of things without negligence on the part of somebody other than the Plaintiff.

3) The circumstances must point to the negligence in question being that of the Defendant rather than that of any other person (*Plateau State Health Services Management Board & Anor v Philip Fitoka Goshwe*, 2012).

In a later part of reviewing the *Philip Fitoka Goshwe* case, after referring to some other pertinent cases, the court, per Alagoa JSC, added, "[t]he presumption of negligence that Res ipsa loquitur impsoses is rebuttable. It is thus for the defendant to show that he was not negligent." (*Plateau State Health Services Management Board & Anor v Philip Fitoka Goshwe*, 2012).

In summation, *res ipsa loquitur* can be described as an instance of circumstantial evidence that can be pleaded and raised, for the purpose of making deduction of negligence on the part of the defendant. In essence, it operates to ameliorate the burden of proof of negligence on the claimant by *prima facie* shifting the burden of explaining absence of negligence onto the defendant. The import is that the defendant will lose the case if he is unable to discharge the imputation of negligence by adducing cogent evidence to explain the absence of negligence on his part or his agents for the occurrence and related injury to the claimant. Inversely, where the claimant solely builds his case on *res ipsa loquitor*, he will lose the case if the defendant is able to explain or justify lack of negligence on his part or agent.

There is a plethora of cases on the operation of *res ipsa loquitor* in the more restricted context of medical negligence in Nigeria and other jurisdictions (Obafemi, 2017). For example in the case of *Abi v Central Bank of Nigeria & Ors.*, 2011, the plaintiff-patient undertook treatment at the second defendant hospital. The plaintiff-patient sued, contending that he was negligently diagnosed to be suffering from cerebrospinal meningitis (CSM) and was treated with various drugs, including gentamycin which made him permanently deaf due to complication of the drugs. *Res ipsa loquitur* was pleaded. Ultimately, it was held by the Court of Appeal that the plaintiff-patient had failed to prove negligence. With reference to the aspect of *res ipsa loquitur*, as basis of proof of negligence in the case, it was held,

[u]nfortunately…there is no direct credible evidence on which the court

> can infer what caused the loss of hearing. The plea of *res ipsa loquitur* would have been available to the plaintiff if he adduced evidence to show that the injury would not have happened without likelihood of lack of care by the defendant. It is after the plaintiff has established evidence from which negligence is inferred that the burden shifts to the defendants to rebut any presumption of negligence (*Abi v Central Bank of Nigeria & Ors.*, 2011).

Also, in the Supreme Court case of *Plateau State Health Services Management Board & Anor v Philip Fitoka Goshwe*, 2012, the plaintiff/respondent attended the defendant/appellant's hospital for treatment of pneumonia. Following administration of some drugs on him he became completely deaf. He instituted an action for medical negligence, pleading *res ipsa loquitor*. The Supreme Court, per Alagoa JSC, held:

> What conclusion can one reasonably draw from a case in which a man who is hale and hearty but for a complaint that he has pneumonia and so proceeds to a hospital to have that ailment treated but comes out of the said hospital with a completely different and worse ailment after taking some drugs administered by the hospital's personnel? The scenario is worse when no attempt is made by the hospital authorities to explain its own side of the story after promising to do so... [T]he evidence led by the plaintiff and lack of same by the defendants having chickened out of an opportunity to state their own position…and the sheer force of the other exhibits…having been rejected, the defendants were properly found liable in negligence and res ipsa loquitur applied." (*Plateau State Health Services Management Board & Anor v Philip Fitoka Goshwe*, 2012).

Apart from the ones earlier mentioned, there are other cases in Nigeria and allied jurisdictions in which *res ipsa loquitor* has been applied in adjudication of medical negligence cases. Examples include *Lagos University Teaching Hospital v Yemi Lawal*, (1982), *Ojo v Gharoro & Ors*, (2006) as well as *Asantekramo alias Kumah v Attorney-General* (1975) in Ghana and *Muchoki v Attorney-General* (2004) in Kenya.

5.4. Defences in Medical Negligence Actions

In medical negligence suits, the defendant doctor can raise some legal defences to the claims. Generally, the defendant, as in other legal actions, can resist the claims of medical negligence on the generic ground that the claimant *has not proved* his case on the preponderance of evidence. Thus, to illustrate, the defendant can argue, *inter alia*, that the claimant has not convincingly established that the defendant owes the defendant a duty of care or has breached a duty of care, or that a breach in question is the cause of a resultant damage as claimed by the claimant. Where a defendant successfully shows that there has not been *negligence*, as legally structured, the suit will be defeated (*Unilorin Teaching Hospital*

v Abegunde, 2015; *Abi v Central Bank of Nigeria & Ors.*, 2011, and *Ojo v Gharoro & Ors.*, 2006). This head of defence can also apply in vicarious litigations involving the hospital employer of a doctor, as liability of the vicarious party is can only arise following the primary liability of the doctor-defendant working in the course of his employer-employee relationship (*Lagos University Teaching Hospital v Yemi Lawal*, 1982). In similar vein, a vicarious party can avoid liability on the ground that the primary defendant is not its *servant* but an independent operative. The issue of lack of *locus standi*, especially in case of proxy litigations, or "no cause of action" can also be raised as in the cases of other court actions.

Apart from the general defence of *no proof*, there are also some specific defences that a defendant may raise. These defences can be absolute in entirely defeating the claim or may be partial as in reducing damages. Some of these specific defences are considered below.

1) That the claim is out of time or that the action is *statute barred*

Generally, there are specified time frames or limits in which civil actions can be instituted in court. If a person institutes an action out of permitted time, the action and drive for redress will fail. *Limitation of actions* is generally governed by statutes, such as the *Limitation Law* and *Public Officers Protection Law*, Laws of Ogun State, 2006; *Limitation Law*, Ogun State Vol. 3 Laws of Ogun State [Nigeria] 2006 respectively. That a suit is statute barred is an absolute defence that would foreclose the claims absolutely. With medical negligence actions falling under Tort Law or Contract Law, it is crucial that a litigant takes cognizance of the applicable *limitation laws* as operative in pertinent jurisdictions. In that respect, the pertinent laws in each jurisdiction must be researched into in reaching decision whether to institute legal action on medical negligence; if not, a litigant may embark on a litigation project that will end in futility.

2) Contributory Negligence and failure to mitigate loss

Where a claimant fails to take reasonable care of himself, or negligence is found on his part in some ways, and this contributes to the harm or loss that he suffers, then a defendant may claim that the plaintiff's own contributory negligence should be taken into consideration in the determination or assessment of awardable damages. *Contributory negligence* is a mitigating "defence" against awards or compensation that could ordinarily have been awarded against the defendant and in favour of the claimant in a suit (*United Bank for Africa and Anor. v Ngozi Achoru*, 1988). The implication is that the compensation payable to the claimant in such circumstances would be reduced to such extent as is just and equitable. It is for the court to determine what is "just and equitable" by considering the circumstances and facts of the case *vis-a-vis* the claimant's portion in the responsibility for the overall damage suffered. For example, if a doctor prescribes a line of treatment or medications for the patient-claimant and the patient fails to faithfully keep to same, or engages in some harmful acts resulting in harm or damage, the patient can be held to have contributed to the damage even where the doctor-defendant has been negligent in some basic respects

(Obafemi, 2017).

In a related vein, the aspect of a duty to mitigate loss or injury can be considered. It is a trite principle that an injured party has a duty to mitigate his loss (*Arojojoye v Wata Timber Co. Ltd.*, 1966; *Benjamin Obasuyi and Anor. v Business Ventures Ltd.*, 1994). Thus where a patient suffers an injury due to a doctor's negligence, the patient reasonably cannot be expected to leave the injury untreated with the mindset that the doctor 'caused it' and is accountable. If the injured patient leaves the injury untreated, festering and becoming gangrenous leading to amputation or other situation, the patient can be held accountable for dereliction of the duty to mitigate loss and his portion of dereliction can be held against him in the assessment of the compensation payable for the overall damage.

3) Voluntary Assumption of Risk

Voluntary assumption of risk, *volenti non fit injuria*, is a defence connoting that no legal wrong is done to one who has consented to the wrong in question. It is an absolute defence connoting that if a defendant can establish voluntary assumption of risk on the part of the claimant, the claimant's claim would fail. *Volenti non fit injuria* can be connected with consent as a defence to intentional torts. However, there appears to be a point of divergence; voluntary assumption of risk involves the claimant consenting to the *risk of* an invasion of his interest, "consent", translates to the *actual* invasion of his interest. Albeit, both entails the claimant's approval which can be express or implied.

In establishing a defence of *volenti*, the defendant needs to show that the claimant actually knows of the danger as compared with what the claimant *ought* to know, and that the claimant fully appreciates the scope of risk and he voluntarily, consciously, expressly or impliedly, accepts the risk.

It bears stating that in the context of medical negligence, the defence of *volenti* can be very difficult to sustain. For example, essentially, the mere fact that the claimant agrees to undertake a risk, such as surgery, does not mean that he accepts that the activity consented to would be undertaken *negligently* by his doctor. However, *volenti* may apply where a doctor proposes and the patient approves of a doctor "taking a chance" in a risky line or approach of treatment, perhaps generally medically untested or debatable by peers or regulatory bodies, in the hope of receiving cure or improving the patient's desperate health condition. This can be illustrated by the situation of some HIV infected patients submitting to controversial HIV remedies proffered by a medical doctor and one scientitst in Nigeria at a time (Muanya, 2019; Ogundipe, 2017).

One aspect where *volenti* can also operate in conventional medical situation is the aspect of *Respectable Minority Principle* (FindLaw's Team of Legal Writers and Editors, 2016). Sometimes a doctor may decide to pursue a new or more radical form of treatment in order to effectively treat a patient. While the decision may place the doctor outside of the medical mainstream, he or she could have a valid defence to a claim if a respectable minority of medical professionals support the line of treatment. It is important that the doctor first informs the pa-

tient about the risks involved.

Inferably, in such a situation, it may not be said that a "reasonable doctor" would and should not have undertaken such approach if the patient comes to harm. Whatever the case is, the onus lies on the doctor-defendant to establish the essential elements of the defence of *volenti* if he opts to plead or raise it.

4) Peer Professional and Accepted Practice or approach

Generally, pertinent jurisprudence permits a doctor to plead and argue in defence that, notwithstanding that injuries occur to the patient-claimant, he (doctor) has met the standard of care expected of a medical professional in his jurisdiction of practice or locality. In essence, this discussion dovetails into the scope of the *Bolam* and *Bolitho* tests. The essence of the *Bolam* test, established in the English case of *Bolam v Friern Hospital Management Committee*, 1957 is that a doctor would not be held accountable for negligence if he acts in accordance with a practice approved by a responsible body of medical professionals skilled in the practice. The *Bolam* test has faced some criticisms. Among others, an author has referred to the test as

> strong judicial deference to the customary practices of medical and other professionals...which amounted to close to complete surrender to the medical [profession] to determine the standard by which it was to be judged. There are some good reasons for such deference: most professionals, after all, are highly intelligent people, engaging in a vocation with traditionally strong ethical standards, policed by a system of professional monitoring and sanctions. Nevertheless, while some deference was appropriate, a virtually complete surrender to customary professional practices clearly went too far." (Obafemi, 2017)

The *Bolitho* test or, more appropriately put, a "qualification to *Bolam* test", emerged in the case of *Bolitho v City and Hackney Health Authority*, 1988. Put simply, the *Bolitho* test connotes that a body of opinion held or a medical approach approved by a responsible body of medical professionals skilled in the practice can still be held for negligence if such opinion or approach fails to withstand logical analysis in matters of medical judgment, involving diagnosis and treatment (Obafemi, 2017). It has been observed that *Bolitho* was not meant to be revolutionary, as in neutralising *Bolam*; as it was noted in the case, per Lord Browne-Wilkinson, it would seldom be right for a judge to conclude that views genuinely held by a competent medical expert were unreasonable. Indeed, the continuing relevance of *Bolam* was alluded to in the 2012 Nigerian case of *Abi v Central Bank of Nigeria*. In *Abi*, it was held *inter alia*:

> The courts have long recognized that there is no negligence if a doctor exercises the ordinary skill of an ordinary competent man professing to have that special skill. The locus classicus of the test for the standard of care required of a doctor or any other person professing some skill is the direction to the jury given by McNair J in Bolam v Friern Hospital Management

Committee (*Abi v Central Bank of Nigeria & Ors.*, 2011).

Without prejudice to the interface between *Bolam* and *Bolitho*, the central issue is that a doctor can raise, as defence, the fact that the medical approach adopted in treatment is in consonance with accepted practice.

6. Remedies for Medical Negligence

The essence of medical negligence suit is to obtain pecuniary awards or *damages* for the damage, loss or injury suffered. In determination of the appropriate awards, the nature of injury, for example, whether personal injury or death becomes pertinent. Damages can be nominal, general, special, punitive or exemplary (Chijioke, 2007).

6.1. Damages for Personal Injuries

Damages in a medical negligence suit for personal injuries, conventionally, would be awarded as a lump sum (*United Bank for Africa and Anor. v Ngozi Achoru*, 1988). The claimant needs to thus ensure that his claims adequately cover his losses, presently and in reasonably predictable future post-trial situations. Damages are not meant for the claimant to unjustly enrich himself at the expense of the defendant; hence, damages would be awarded in the framework of facts and evidence presented to the satisfaction of the court. Perhaps, it bears adding that such awards must relate to or be connected with the negligent act of the defendant and naturally resultant injury constituting the basis of claims.

General damages for personal injuries are pecuniary awards for losses that are naturally and reasonably resulting from the defendant's wrongful act of medical negligence. These can include pains and sufferings, loss of the amenities of life, inconvenience and disability, and disfigurements (*Agaba v Otobosin*, 1961). It is trite principle that the award of general damages lies at the discretion of the court to be judiciously and judicially applied.

Special damages are compensation for expenses or losses that are natural consequences of the injury suffered by the claimant due to the defendant's tortious wrongful act (*Alhaji Otaru and Sons Ltd v Audu Idris & Ors.*, 1999). In the case of a medical negligence suit, these can include medical and related expenses for treatment or care following injury from the defendant's negligent act, loss of earnings, and other expenses incurred for special needs or requirements by the claimant arising from injury suffered by the claimant due to injury caused by the defendant's negligence. A claimant seeking special damages for medical negligence carries the burden to specifically plead and strictly prove same before the court (*Alhaji Otaru and Sons Ltd v Audu Idris & Ors.*, 1999).

Punitive or Exemplary Damages are legal damages that a court may grant a plaintiff to punish and make an example of the defendant (*Eloichin (Nigeria) Ltd. v Ngozi Mbadiwe*, 1986). Punitive damages are generally awarded in special and restricted circumstances, such as where the wrongful act is sufficiently condemnable to merit punishment (*Eloichin (Nigeria) Ltd. v Ngozi Mbadiwe*, 1986).

Thus, in the case of medical negligence, this may arise where the defendant-doctor's act is grossly negligent, oppressive, nonchalant or arbitrary. In such cases, the plaintiff may thus recover punitive damages in addition to the general or special damages for the sake of making an example of the defendant through further sanctioning (Ogunniran, 1992). The scope of exemplary damages, as set out in the English case of *Rookes v Barnard*, 1964 appears restricted than the scope under Nigerian jurisdiction, and it has been held that *Rookes v Barnard*, though persuasive, is not binding on Nigerian courts (*Eloichin* (*Nigeria*) *Ltd. v Ngozi Mbadiwe*,1986; Atsegbua, 2013). Along this axis, ostensibly, in appropriate cases, where properly claimed and proved, claimant may be awarded exemplary damages for medical negligence in Nigeria.

6.2. Damages for Death Occurring through Medical Negligence

Where an act of medical negligence results in death, survivors that may be dependants, executors or administrators of the deceased can institute a suit for claims which the deceased could have had if alive, or claims for losses they have personally suffered as a result of the deceased's death (*Tarassoff v Regents of the University of California*, 1976; *Raimi Jenyo and F. A. Aderemi* (*Administrators of the Estate of Basiratu Raimi* (*Deceased*) *v Akinsanmi Akinreti and Anor.*, 1990); *Aderinola Adeyemi and Ors. v Shittu Bamidele and Anor.*, 1965; *Taff Vale Railway v Jenkins*, 1913). Previously, under Common Law rules, action could not be maintained for the tortious death of a person, as right for action was extinguished with the death of the victim and the death of a person could not be complained of as an injury (*Baker v. Bolton*, 1808).

However, it became trite that actions for wrongful death could be instituted in Nigeria as provided, for example, in the *Fatal Accident* of Lagos State, 1961 *Civil Liability* (*Miscellaneous Provisions*) Law of Lagos State, 1961 and *Torts Law* of Ogun State, 2006. To illustrate, Section 3(1) of the *Fatal Accidents Law* of Lagos State, 1961 provided:

> 3. (1) Where after the coming into operation of this law the death of a person is caused by' wrongful act, neglect or default, and the wrongful act, neglect or default is such as would, if death had not ensued have entitled the person injured to maintain an action and recover damages in respect hereof, the person who would have been liable if death had not ensued shall be liable to an action for damages notwithstanding the death of the person injured.
>
> (2) Every action under this section shall be for the benefit of the members of the immediate family of the deceased person and shall:
>
> (a) if the deceased person was not subject to a system of customary law, be brought by and in the name of the executor or administrator of the deceased person; or
>
> (b) if the deceased person was immediately before his death subject to a system of customary law relating to estate, be brought at the option of his

> immediate family, by and in the name of such person as the court is satisfied is under the customary law, entitled or empowered to represent the deceased person or his estate.
> (3) If there is no executor or administrator, or where there is in executor or administrator but no action is brought by the executor or administrator within six months after the death of the deceased person, then action may be brought by and in the names of all or any of the persons for whose benefit the action would have been if it had been brought by the executor or administrator, and every action brought shall be for the benefit of the same persons and be subject to the same regulations and procedure as nearly as may be if it had been brought by an executor or administrator.

The rights of survivors of a deceased person to institute actions for negligence in Nigeria have been judicially recognised and upheld in cases, such as *Raimi Jenyo and F. A. Aderemi* (*Administrators of the Estate of Basiratu Raimi* (*Deceased*)) *v Akinsanmi Akinreti and Anor.*, 1990. In instituting medical negligence actions based on "wrongful death", some points are to be noted. One is that, to recover, the claimants must establish the claim of negligence against the defendant just as the deceased would have had to do if alive and instituting the action personally. The claimants too must establish legal relationship with the deceased as to confer *locus standi* on them. Any claimant unable to establish the required legal relationship in such situation would not be able to recover (*Aderinola Adeyemi and Ors. v Shittu Bamidele and Anor.*, 1965). In respect of claims based on the death of a minor, there is also the need to establish dependency or a reasonable expectation of future pecuniary benefits; where these elements are not established the claims for the death of minor would fail (*Raimi Jenyo and F. A. Aderemi* (*Administrators of the Estate of Basiratu Raimi* (*Deceased*) *v Akinsanmi Akinreti and Anor.*, 1990, *Barnett v Cohen*, 1921).

7. Medical Negligence as a Relatively "Unexplored Terrain": an Overview of Medical Negligence Litigations in Nigeria

From a historical perspective, the earliest reported case of medical malpractice was the English case of *Stratton v Swanlond* which was decided in 1374 (Chapman, 1982). In the case, a surgeon tried to repair a woman's mangled hand. The woman claimed the surgeon said he could cure her, but after the procedure she was still deformed. The case was dismissed on a procedural error, but the judge set ground rules for contemporary medical negligence cases, stating that physicians could be held liable when they are negligent, but if properly treated, they would not be liable just because it did not cure the patient.

Reports indicate that the occurrences of medical negligence are significantly high in Nigeria (Olofinlua, 2015 [Part 1]; Olofinlua, 2015 [Part 2]; Owoseye, 2018) "...[W]hile there is no incontrovertible data on the actual number of medical negligence cases in Nigerian hospitals, patients and medical practitioners alike acknowledge that number to be very high." (Olofinlua, 2015 [Part 1]).

While the incidents of medical negligence have been high, a comparatively low number are litigated in the courts for redress due to some factors. "Many people die in Nigerian hospitals as a result of medical negligence, yet few cases of medical negligence are ever reported, and even fewer prosecuted. Long trial periods, corruption and a general mistrust of the judicial system are a few of the reasons many Nigerians think twice before filing a case of medical negligence in the courts" (Olofinlua, 2015 [Part 2]).

With its connection to English Law, Nigeria, through the courts, has developed a quite noticeable jurisprudence on medical negligence over the years (Kuteyi, 2016; Obafemi, 2017). However, as pertinent literature indicates, the volume of medical negligence litigations in Nigeria, despite reported large scale of occurrences, is relatively low when compared with countries of the West such as United States of America and Britain (Odunsi, 2019). This scenario can be attributed to some factors. Perhaps, one is the widespread socio-cultural attitude of preferring reconciliation to pursuits of redress through the adversarial court mechanisms with the attendant "headaches" and the ultimate by-product of "enmity" (Oyelade, 2005).

In the aspect of medical litigations, the situation, perhaps, can further be attributed to widespread religious attitudes of ascribing medical and other tragedies to divine predetermination or fate, over which humans have no control; and ones which no court actions can undo what have been done. In a related vein, the religious attitude of adopting forgiving spirits, in some cases, can operate in influencing some people in not seeking legal redress in court in the event of medical misfortune attributable to the act or omission of a doctor.

Large scale poverty with the attendant inability to afford legal expenses can also be cited as a factor that might have made medical litigation an unattractive choice for many Nigerians (Odunsi, 2010). As T. Akinola Aguda, a renowned scholar and jurist, lamented over the Nigerian justice system:

> [i]t is a sad reflection of our administration of justice that to a very large extent the quality of justice one is able to achieve from judicial proceedings depends to a large extent on how much money he is able to spend on the proceedings…but how can a poor citizen existing at bare starvation level hope to have equal opportunity of success in any litigation between him and the State which has in its pay roll a large number of seasoned lawyers paid from public funds. The position is not much different if a poor man is engaged in litigation against a millionaire able to engage the best brains the legal profession is capable of providing (Akinola-Aguda, 1986).

Therefore, even where a person, directly or indirectly aggrieved by a medical incident, is desirous of pursuing a claim through the court, financial incapacitation may impede him or her from accessing the court. Beyond financial limitations, there is also the issue of relative doubt of confidence in the Nigerian justice system as a discouraging factor (Odunsi, 2009). In light of the foregoing factors, it is not uncommon for aggrieved Nigerians, for different reasons, to

"leave things to God" rather than pursue legal redress in court.

Admittedly, the factors noted above are not restricted to discouraging only medical litigations in Nigeria; the factors do apply to litigations in other ramifications (Odunsi, 2019). However, for some reasons, the factors can have more pronounced effect in the aspect of medical litigation. It is trite that ill-health, especially in serious cases, tend to have serious psychological and financial impacts on the sick person, relatives and others affected by the illness of the sick person. Any negative outcome in the medical treatment process may add further burdens, which may make court action another level of undesired trauma, or an issue of less worry, for people trying to come to grasp and cope with the misfortune, or seeking to get over the matter and "move on".

The following account is pertinent in the context.

> In December of 2012, Ruth went into labour with her first child at a private hospital in the Iyana-Iba area of Lagos. She was in labour for twenty-two hours. She says that when her daughter was eventually born, the baby was in distress but did not cry. Ruth alerted the doctor. "I asked the doctor to see my baby because I did not hear her cry. He replied jokingly: "take cane and flog her now," she recalls.
> ..."I started complaining to them when, on the third day, she was not making any sounds. The hospital staff said she was fine." But on the fourth day, Ruth's daughter had a seizure. "The doctor could not tell what was wrong. He referred us to a government hospital." Ruth visited the newly commissioned Mother and Child Hospital in Lagos. There, her daughter was rushed into emergency and given an anti-seizure injection. A brain scan at Yaba Psychiatry showed that Ruth's daughter suffered from primary generalised epilepsy. She was placed on daily medication to lessen the frequency of the seizures. After consulting with several medical experts, Ruth learned of two likely causes for her child's condition. "First, by not crying immediately after birth, a part of her brain did not take in oxygen. Second, she also had hypoglycemia—low blood sugar. Her blood sugar level was 15. It is not supposed to be lower than 40 for a newborn." With this discovery, Ruth became angry at the hospital, and at the doctor for being careless. Ruth pays the price of that carelessness daily. The drugs her daughter needs cost ₦2050 per bottle, and she buys a new bottle every 10 days. During her daughter's most recent seizure, Ruth turned to check on her in the backseat on their way to the hospital and drove into an electricity pole. Fixing the pole cost her ₦90,000; repairing the car, ₦180,000. But even these staggering financial costs do not begin to compare with the emotional burden of raising a chronically ill child. "[The seizures] can happen anytime, anywhere, so you have to be on the lookout," she says, adding that people have advised her to visit prayer mountains for solutions. *Ruth says that she is considering pressing charges against the hospital, but worries that it will be too hectic. Raising a child who may suffer a seizure at any time is difficult*

> *enough for the mother of two, and she worries that legal proceedings might be too much to bear*. (Olofinlua, 2015 [Part 2]).

Comparatively, in litigations over commercial matters, land, political, official or royal positions, litigants have expectations of financial gains or some other benefits which can be stimulating incentives to go to court. Damages are the conventional remedies awarded in medical litigations. While damages offer hope of financial relief, this may not be strong incentive to embark on medical litigation for some, as damages may be seen as having limited restorative value. To illustrate, it can be said "what impact would payment of damages have in a case where a patient has died as a result of a medical incident?" Considering the financial and other rigours that court action can entail, the affected person may not consider litigation worthwhile and may rather philosophically conclude that "no amount of money can bring back the dead."

Doubts over chances of success can also be a factor inhibiting aggrieved persons from embarking on litigation for medical negligence in Nigeria. As a source portrays the scenario,

> [a]nother thing that also happens is that with the ticking of the clock, self-defeating thoughts often creep into many Nigerian hearts, … "They will ask: 'Will I even succeed? How long will it take? If I go there now, maybe the people will get the judge compromised or they will hire a lawyer better than mine. Or I will go there and seek one million naira after spending 500, 000 naira, and the judge may award 30, 000 naira.'" (Olofinlua, 2015 [Part 2]).

In some cases, where there has been long standing doctor-patient relationship between the parties, and the doctor has generally been of good report before the incident, the aggrieved may not consider litigation appropriate in such situation with the sentimentality of avoiding "biting the hand that has fed" or simply attributing the occurrence to a philosophy of *quid sera sera*. This is more likely to the case when the doctor in question has been sincerely remorseful, placatory or apologetic.

In a society where there is large scale illiteracy, lack of understanding or awareness of the rights of legal action over unwholesome medical incidents, may also have played a role in preventing some medical negligence cases getting to court. This may particularly play out among rural populations for whom having access to doctors appear to be huge privileges. Some may even perceive doctors as "angels" who, possibly, can do no wrong and thus unassailable. As a legal practitioner, Laolu Osanyin captures it,

> [h]istorically, the Nigerian doctor was equated to the status of a healer or a priest who could do no wrong... Those days, if anything untoward occurred in the treatment of a patient, the doctor was usually the last person to be held accountable. The Nigerian patient or their families will locate someone in the village who they can hold responsible for the problem; if they find no

> one to drop the problem at their doorstep, they say it is destiny (Olofinlua, 2015 [Part 2]).

Notwithstanding the foregoing, it would be precarious for any doctor in Nigeria to assume any feeling of insulation from litigation. As the available Nigerian jurisprudence on medical litigation indicates, there are people who would not shy away from suing doctors for perceived wrongdoing whatever the situation. Moreover, the increasing presence and intervention of human rights lawyers, human rights and related activists, Civil Society Groups and other entities willing to fight on behalf of the "helpless" tend to increase the possibility of aggrieved patients being led into court battle against a doctor, though such persons might not have done so ordinarily. In this respect, one may readily recall, though not exactly in a doctor-patient or medical negligence scenario, the dramatic case of *Georgina Ahamefule v Imperial Medical Centre and Dr Alex Molokwu*, filed in 2000 and judgment delivered in 2012 (Ogbo, 2012) which was spearheaded by a Civil Society Group. Also, the ubiquitous internet and Nigerian social media, with the propensity for sensationalism, raise the probability of instigating or gathering army of "defenders of the helpless" that may propel legal action which might not have ordinarily arisen. To sum up, the point is that, unlike in the past, there are now compelling factors that may propel a doctor's alleged wrongdoing to court which may even be beyond the control of the aggrieved patient of proxies. The following account tends to illustrate the emerging scenario:

> Despite the many challenges involved in pursuing justice in cases of medical negligence, there has actually been an increase in the number of Nigerians reporting medical negligence. In the 36-year span between 1962 and 1998, there were 94 cases of medical negligence reported to the Medical and Dental Council of Nigeria, compared with over 100 cases in the six-year span between 1999 and 2005. Laolu Osanyin believes this can be attributed to globalization, and the Internet in particular. "People who have families that have done certain procedures abroad and hear of people dying of said procedures here have started questioning doctors." (Olofinlua, 2015 [Part 2]).

8. Medical Litigations: Doctors' Dilemmas as Matters Arising

To recap, the contemporary outlook of doctor-patient relationship is such that every doctor runs the risk of litigation from an aggrieved patient or proxy in the course of the doctor's professional duties. On the whole, there is a seeming paradox in the doctor's ethical burden to do *good* or act in the best interest of his patient, as prescribed in the Hippocratic Oath, or overall public interest in some situations. As the following discussion shows, it appears that a doctor is prone to litigation in, literally, all ramifications of doing good for his patient.

On humanitarian grounds, a doctor in doing good for his patient may be prompted to paternalistically adopt treatment measures that are professionally considered beneficial to the patient, though not approved by the patient. Despite

achieving positive or medically advantageous outcomes for patients on such Good Samaritan platforms, doctors have faced litigations by patients for such "good acts" (*Schloendorff v Society of New York Hospital*; *Murray v McMurchy*, 1949). Perhaps, it can be argued that a doctor who paternalistically plays Good Samaritan and gets rewarded with a biting litigation "asked for it" and deserves what he gets for being an interloper stepping out of bounds in the doctor-patient equation. Along this axis, by way of exhortation, it may be pertinent to re-echo that doctors would "do well to remember what Lord Devlin said, albeit in a rather different context: 'The Good Samaritan is a character unesteemed in English Law'" (Mason, McCall Smith, & Laurie, 2002); same admonition would also apply to doctors operating under Nigerian law as well as Nigerian medical law.

Perhaps, a more intriguing dimension in the paradox is that a doctor is still vulnerable to litigation where he acts for the "good" of the patient by respecting the wishes of the patient in refraining from treatment measures refused or disapproved by the patient, but there follows a negative medical outcome. The Nigerian case of *Medical and Dental Practitioners Disciplinary Tribunal v* Okonkwo, 2002, offers a dramatic illustration. Briefly, in *Okonkwo's* case, a referred anaemic patient insistently refused blood transfusion on religious ground of being a member of Jehovah's Witness group, whose tenet does not approve of blood transfusion. In the doctor's professional assessment, blood transfusion was the most promising medical option in the circumstances of the patient. In respecting the religious right and wishes of the patient, the doctor refrained from blood transfusion; eventually the patient died. The woman's family, excluding the husband, petitioned the Medical and Dental Practitioners Council which led to a sanction of six months suspension of the doctor. The doctor challenged the decision of the tribunal in a suit that ultimately got to the Supreme Court, Nigeria's highest court, where the doctor was eventually exculpated.

Furthermore, that a doctor, in the act of doing good or acting in the best interest of his patient, follows prescribed or acceptable procedures, as well as due process, in good faith in treating a patient does not insulate the doctor against litigation. The 2019 Supreme Court case of *Esabunor & Another v Faweya & Ors*. is considered an apt illustration in this context. In the case, a doctor was faced with the treatment of a patient who was a child and, legally, a minor. The diagnosis indicated that blood transfusion was necessary in treating the child. The parent on religious ground refused to consent to blood transfusion. The doctor and hospital sought and obtained a court order to undertake blood transfusion in the best interest of the child-patient and public policy.

Subsequently, the parent sued, among others, the doctor and hospital employer, challenging validity of the court order which overrode her proxy refusal of blood transfusion for the child. The case, over a period of about twenty-two years, went through different levels of the Nigerian court system up to the Nigerian Supreme Court where the doctor's approach in obtaining court order, in sidestepping the parental objection to blood transfusion, was held legitimate and proper. Put in another perspective, the doctor was held to have acted *reasonably*

and justifiably in the approach taken in treating the child-patient, after having to grapple with a lengthy legal battle of about twenty-two years, with the financial and other stresses. Perhaps, it bears stating that the child-patient in question got well and healthy through the applied blood transfusion and had grown into a twenty-two-year-old adult by the time the case came to an end at the Supreme Court.

Though not in a strict doctor versus patient scenario, the 2012 case of *Georgina Ahamefule v Imperial Medical Centre and Dr Alex Molokwu* (Ogbo, 2012) offers another illustration into the dilemma of doctors in the task of doing good for their patients. The plaintiff in the case, Ahamefule was an auxiliary nurse in the first defendant hospital with the second defendant, Dr. Molokwu, as proprietor. At some point, the plaintiff was diagnosed to be HIV positive. Ostensibly, in a zealous drive to avert possible transmission of HIV to the defendants' patients, with whom the plaintiff as an auxiliary nurse would necessarily interact in the hospital setting, the defendants sacked the plaintiff. With the intervention of a civil society group, the defendants were sued for wrongful termination of employment on the human rights ground of discrimination against the plaintiff on health status. After a circuitous court odyssey, the defendants were found liable with damages of seven million Naira awarded against them and in favour of the plaintiff (Durojaye, 2013). Added to professional legal fees and expenses with related stresses, this case is a forlorn illustration of the financial and other burdens which a doctor may be prone to in the course of seeking to do good for his patients.

Quite true, the aspect of human rights violation in the sacking of Ahamefule by her employers, *vis-à-vis* the pertinent jurisprudence, cannot be sanctified in any way. The series of academic postulations and the judicial position on the *Ahamefule* case highlight the need to safeguard human rights of the plaintiff, just as those of other citizens (Odunsi, 2010; Durojaiye, 2013). Nonetheless, the *Ahamefule* case is indicative of the legal and ethical conundrum that doctors have to wrestle with in the course of doing good for their patients. One poser that can be raised along this axis is: what could have been the outcome if the hospital and doctor in that case did not take the measure of laying-off the HIV-infected auxiliary nurse, and one or more of the doctor's patients got infected with HIV through interactions with the nurse resulting in litigation by the infected patients on the ground of the doctor and hospital's default?

In perspective, the earlier noted cases of *Okonkwo*, in one respect, and *Faweya*, in another, portray the likely dilemma of doctors in the project of safeguarding patients' interest *qua* the patients. *Ahamefule* case, at another level, seems to symbolize the likely predicament of doctors in deciding on which side to tilt where patients' interests conflict with individual third-party interests or collective public interest, such as assisting law enforcement agents in crime control or prosecution or notifying persons at risk of being infected with contagious diseases (Odunsi, 2006; Odunsi, 2007). Simply, a doctor carrying the burden of

acting in his patient's best interest may, literally, find himself on "horns of dilemma" when the patient's interest is in contest with other persons' or general public interest. The doctor in *Ahamefule* case would appear to have readily, even if summarily and drastically, put the health interest and good of his patients over and above the human right and employment interests of the plaintiff as a third party. For this, he reaped a litigation headache and consequential judicial sanctioning.

The dilemma of a doctor in an attempt to resolve such "patient versus others" puzzle can be quite confounding at times, going by a juxtaposition of the two cases of *Tarassoff v Regents of the University of California* (1976) on the one hand and *Duncan v Medical Practitioners Disciplinary Committee* (1986) on the other. The two cases relate to the ethical duty of doctors to keep the confidence of patients, violation of which can be a ground for a charge of inappropriate conduct against an erring doctor. In the case of *Tarrasof*, a mental patient informed his doctor of his intention to kill a lady that had spurned his love advances. The doctor, apparently, in safeguarding his patient's interest by keeping his confidence, failed to notify or warn the potential victim. The patient eventually carried out his intention by killing the lady. The doctor and his employers were found liable in a suit instituted by the lady's family. In the case of *Duncan*, the patient who was a public bus driver suffered from a heart condition. On learning that the patient was to resume driving passengers his doctor informed potential passengers of the patient's health condition and the threat he constituted to their safety. The doctor was found culpable for unethical conduct, among others, on the ground that he informed inappropriate parties.

It is noteworthy that the two cases of *Tarrasof* and *Duncan* are cases arising in jurisdictions with Common Law background just as Nigeria. The two cases are thus applicable in Nigerian courts and jurisprudence as *persuasive* authorities. While the two cases have to be considered in their respective material contexts, a pertinent fact is that the two cases hold different positions on a substantially similar issue—that is, doctors *warning* or *failing to warn* persons to whom the doctors' patients constituted harmful risk.

The propriety of making doctors to operate under a stifling legal regimentation and attendant threat of litigation has been, and will continue to be, a subject of emotive debate (Mason, McCall Smith, & Laurie, 2002). However, the prevailing reality is that doctors have to interact with their patients in an atmosphere with litigation dangling over them like the idiomatic *Sword of Damocles* (MacMillan Dictionary). One likely implication of this scenario is that in dealing with a patient a doctor may embrace "defensive" or self-preserving attitudes for his own *good*, with greater concern on avoiding legal and ethical pitfalls or heartaches of litigation, rather than going extra mile or taking risk that may better serve the interest of a patient in dire need. This mentality, perhaps, may be a factor in the concurrencies in Nigeria where doctors summarily *reject* or *refer* patients to other hospitals, especially in emergency cases, such as gunshot inju-

ries, instead of taking steps that may primarily assist the situations of the patients. Put simply, a doctor may elect to err on the side of caution by rejecting, referring or refusing a patient so as to avoid litigation or "police troubles" instead of being humanitarian by attending to the patient in the light of the prevailing legal and ethical straitjackets. One likely implication of the scenario is that in dealing with a patient, a doctor may embrace "defensive" or self-preserving attitudes for his own *good*, with greater concern on avoiding legal and ethical pitfalls or heartaches of litigation, rather than going extra mile or taking risk that may better serve the interest of a patient in dire need (Sekhar & Vyas, 2013; Ortashi et al., 2013).

9. Conclusion

Where doctors in the discharge of their professional services act below permissible standards or professional expectation, it is expected that law, as a tool of social regulation and control, intervene in the preservation of the interest of affected citizens. Where doctors do *bad*, or act inappropriately in dealing with patients, it can hardly be debated that such doctors should bear the prescribed sanctions, afforded by litigation, for doing *bad*. This is the point at which medical litigation enters into the jurisprudential topsy-turvy. Situations in which doctors face the rigours and stresses of litigation where they do *good* or act in compliance with due process in undertaking medical treatment of patients, as some cases highlighted above exemplify, call for serious jurisprudential reflection. The point of concern is that, in Nigeria, doctors hardly have avenues for meaningful compensation for the financial and other inconveniences experienced in the course of fighting such undeserved court battles, when and where they are ultimately cleared of any wrong doing.

True, it could be tragic and a source of grief for a doctor who, in his professional judgment and good conscience, acts in the best interest of his patient to get rewarded with stressful and expensive litigation, or, where a doctor in preserving overall public health interests gets into trouble of litigation because of trespassing on the rights or interests of patients. Somehow, that is the reality doctors in the performance of their medical duties have to grapple with in the scope of medical negligence and other genres of medical litigation. Generally, it would seem uncanny for doctors to perceive patients as potential litigants or enemies rather than friends whose best interest doctors have to protect. Similarly, it would be dispiriting for doctors to get into trouble with authorities in the quest of safeguarding public interests by subjugating patients' private interests. It would also be precarious for society where doctors become constrained to focus on *their own* interests over and above patients and public interests, for the sake of staying out of trouble. These and related issues are what the bench, bar and other stakeholders would need to engage in striving for the appropriate balance in adjudications on medical negligence and medical litigations in other ramifications.

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

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