

## MEDICAL ETHICS AND MEDICO-LEGAL ETHICS: A BRIEF ANATOMY OF CERTAIN SALIENT ISSUES

**Prof. PEO Oguno & Dr. Ifeanyi E. Anigbogu**

### ABSTRACT

*In the declaration of a prospective medical or dental practitioner and which is the modification of the Hippocratic Oath are contained the expressions 'I will practice my profession with conscience and dignity' and 'I will maintain the utmost respect for human life from the time of conception'. The implication of the foregoing is that medical ethics and medico-legal ethics, albeit unobtrusively, accompany us with the sterling qualities of durability, beauty and strength from the cradle to the grave. This work, even though a tip of the iceberg has been an attempt to elucidate certain salient indices of the phenomena.*

**Key Words:** *In-vitro fertilization, Cryonics, Nanotechnology, Nanomedicine*

### INTRODUCTION

Much of the ethics of medical practices represents a purely intra professional code of conduct and is better described as etiquette, (medical etiquette). The maintenance of good relations often devolves on the professional association, eg, Nigeria Medical Association and seldom involves a lawyer. Ethics in relation to the patient are, however another matter and may well result in litigation. Since much of this is based on common law or case law, complex arguments may arise.<sup>1</sup>

### MEDICO-LEGAL ETHICS

The primary consideration of medical practice is the welfare of the patient. Not only is the affirmation given to apply one's skill to the patients benefit, but it is positively declared improper to do anything that might harm the patient. Admirable as the tenets of the Hippocratic Oath are, in contemporary medical practice, it has its short comings and therefore needs a buttress by the law. This is where the study and understanding of law and ethics (medico-legal ethics) become a sine que non for acceptable medical practice. Healthcare practitioners should study the law and ethics that relate to their respective professions to help them function at highest possible professional level. As today's world has become more complicated, so too have the practice of medicine and the laws governing the practice, making it necessary for all health care practitioners to be informed concerning their legal and ethical rights and responsibilities.<sup>2</sup>

---

**Prof. PEO Oguno**, Ph.D Dean Faculty of Law, Chukwuemeka Odumegwu Ojukwu University, Faculty of Law Igbariam, Anambra State, Phone: 08034041556, [poguno@yahoo.com](mailto:poguno@yahoo.com)

**Dr. Ifeanyi E. Anigbogu**, MD (General Medicine). Ph.D (Surgery), M.I.S.B.T, LLB (Hons), BL (Hons), LLM (Law), Ph.D (Law), Specialist Surgeon, Solicitor and Advocate of the Supreme Court of Nigeria, Lecturer, Faculty of Law Madonna University, Okija, Nigeria, Phone: 08037031458, [ie07anigbogu@yahoo.com](mailto:ie07anigbogu@yahoo.com)

<sup>1</sup> J.K. Mason. Forensic Medicine for Lawyers. 2<sup>nd</sup> ed. ELBS 1988.

<sup>2</sup> Karen Judson and Sharon Hicks-Glericole Law and Ethics for Medical Careers 2<sup>nd</sup> ed. Gleuco/Mc GrawNill 1999.

The study of law and ethics also brings into perspective the rights responsibilities and concern of healthcare consumers. With the increased complexity of medicine and medical practice, has come the desire of consumers to know more about their options and rights, and more about the responsibilities of healthcare providers. Today's healthcare consumers are likely to consider themselves partners with healthcare practitioners in the healing process and to question fees and treatment modes.<sup>3</sup> Many informed healthcare consumers are even beginning to exercise their rights to question certain diagnoses and how they are arrived at.

Rapid advances in medical technology and increases in medical specialization have added to the legal and medical conundrums. For example, contemporary court cases in civilized societies and advanced countries have debated such issues as:

- Does the husband or wife have ownership rights to a divorced couple's frozen fertilized pre embryos?
- Will a surrogate mother have legal visitation rights to her offspring?
- Should modern technology be used to keep those patients alive, who are diagnosed as brain-dead and have no hope of recovery?
- How should parenthood disputes be resolved for children resulting from reproductive technology?<sup>4</sup>

It is obvious that the interaction between medicine, law and philosophy is no longer in doubt. The interaction is real, with modern advancements in science and technology daily unabashedly staring us in the face. The ability of biotechnology to cause life and prolong it throws up many ethical questions, resolutions of which can hardly be by sheer appeal to individual conscience of the doctor, considering the multidimensional facets which medical services are rendered, and the fact that there is hardly a moral solidarity on the many ethical issues in Medicine.<sup>5</sup>

In Nigeria, the health profession is regulated by statutory laws. Medical practice is governed by the provisions of the Medical and Dental Practitioners Act, 1988. This act or law empowers the Medical and Dental council to determine the standards of knowledge and skill to be attained by persons seeking to become members of the Medical and Dental professional and also review these standards from time to time. The council is therefore responsible for the approval of courses, qualifications and institutions intended for persons who wish to become doctors or dentists in Nigeria.

The council is also empowered through its registrar (who may be a medical practitioner or dental surgeon appointed by the council) to prepare and maintain registers of names addresses qualifications and such other particulars of persons who are qualified and are entitled to practice medicine and dental surgery in Nigeria.<sup>6</sup>

---

<sup>3</sup> -Ibid

<sup>4</sup> Ibid

<sup>5</sup> Festus O. Emiri. Medical law and ethics in Nigeria Malthonic press Ltd.2012

<sup>6</sup> Compendium of medical law under the common wealth and united states legal systems; with treatise on assisted conception by Prof Giwa Osagie Edited by Abibakar Sadiq Oguche. Published by maiyati Chambers. 2006

The Medical and Dental council is empowered to discipline any erring medical practitioner or dental surgeon. There are three broad instances in which the council can invoke its disciplinary powers, namely:

- a. Where a registered practitioner is adjudged by the disciplinary tribunal to be guilty of infamous conduct in a professional aspect.
- b. Where a registered practitioner is convicted by court of law or tribunal in Nigeria or elsewhere.
- c. Where a person has been fraudulently registered.

In addition to the above intra professional cases, circumstances abound, where the medical doctors in course of their daily practice may have a brush with the law while interacting with their patients. These are cases such as:

1. Consent
2. Professional secrecy or Patient-Doctor confidentiality.
3. Medical Experimentation
4. Medical Negligence
5. Euthanasia

### **CONSENT:**

Consent is acquiescence; agreement. It must be real, and given without force, fear, or fraud. Fraud vitiates consent. There is no consent where a man acts under the compulsion of a legal or moral duty.<sup>7</sup>

In medical practice, examination and/or treatment of a patient without his consent may constitute assault, unless an emergency situation exists. The form of consent is, however, not uniform and special difficulties may arise in relation to medico-legal examination that may be positively to the patient's detriment.

In contemporary medical practice, consent *simpliciter* is no longer enough. Consent must be informed, i.e "informed consent". What is meant is that when a person being treated by a physician is an adult, the administration of treatment without that person's consent is a legal wrong – specifically a battery when the body of the patient is touched without his consent. The physician may be liable to the patient not only for any harm that may be occasioned by the treatment, but also, even if there is no harm, for the act of nonconsensual treatment which is regarded as a legal injury.

Furthermore, even if consent was obtained, it is not legally effective if the physician did not explain, before treatment, the relevant therapeutic or diagnostic options and the risks and benefits of each- that is, if the physician has failed to obtain informed consent. Failure to provide required information constitutes the offence of negligence for which damages may be imposed if the patient is injured and if treatment would have been refused had proper information been provided.

Thus, for consent to be deemed as informed consent, it implies that the patient clearly understands what he is consenting to, the possible outcome of the procedure, and possible implications and

---

<sup>7</sup> Osborne's Concise Law Dictionary, 8<sup>th</sup> ed. Edited by Leslie Rutherford; md Sheila Bone. Sweet & Maxwell (1993); See also, Haynes v. Harwood (j). / 1K.B.146"  
Mason J.K. Forensic medicine for Lawyers, 2<sup>nd</sup> society/Butterworih, 1988. 3 hup:  
galcnpress.com/extras/extra21.hlm

complications that may reasonably be expected. Consent obtained otherwise is invalid. The mere fact that a patient complies with a doctor's instructions without saying anything, does not mean that consent has been obtained. It must also be noted that a person cannot consent to a procedure that is illegal, for example, an illegal termination of a pregnancy, feticide or infanticide.<sup>8</sup>

It therefore follows that informed consent is a legal condition whereby a person can be said to have given consent based on proper understanding and appreciation of the facts and implications of an action. The individual needs to be in possession of relevant facts and also of his reasoning faculties, such as not being mentally retarded or mentally ill and without an impairment of judgment at the time of giving the consent. Such impairments might include illness, intoxication, insufficient sleep, and other health problems.<sup>9</sup>

Some acts cannot legally take place without informed consent. However, in cases where an individual is considered unable to give informed consent, other persons in special relationship with him or her may be allowed to give consent on his behalf.<sup>10</sup> Examples of such persons include parents or legal guardians of a child, and caregivers of the mentally ill. In cases where an individual is provided with limited facts, serious ethical issues may arise.

### **Issues Surrounding Assessment of Consent**

Informed consent can be complex to evaluate because neither expression of consent nor expression of understanding of the implications and indeed complications necessarily mean that a full adult consent was in fact given, nor that full comprehension of relevant issues is internally digested. It is difficult for example, for a non-medical mind to fully comprehend the implications of peritonitis as a complication of appendectomy, or thyroid storm as a possible immediate complication of thriodectomy. All the same, many a time, consent is implied within the usual subtleties of human communication. But this notwithstanding, in some cases, consent is legally denied even if the patient admits that he does indeed understand the procedure or treatment in question.

There are structured instruments for evaluating capacity to give informed consent, although no ideal instrument exists as such. There is thus always a degree to which informed consent must be assumed or inferred based on observations, knowledge, or legal reliance. In medical informal circumstances, explicit agreement by means of signature, which may normally be relied upon legally, regardless of actual consent, is the norm.<sup>11</sup>

### **Types of Consent**

Consent may be implied or express.

#### **Implied Consent**

Consent may be taken to be implied when the patient presents himself or herself for treatment or examination. Even so, the implication only pertains to what the patient would reasonably expect, e.g. a patient does not expect a vaginal or rectal examination when she/he complains of a cough,

---

<sup>8</sup> a -. Ibid

<sup>9</sup> -s Ibid

<sup>10</sup> -" *Abdulnuimini H.R. Handbook of Forensic Medicine*. Amana Publishers Ltd. Zaria, 2003.

<http://en.wikipedia.org/wiki/informedconsent>,

<sup>11</sup> - ibid

although a dedicated doctor might contend that a full examination of the patient is necessary for accurate diagnosis. In that case, the doctor should obtain specific consent of unusual clinical methods, and it is well to have the consent given in the presence of a witness.<sup>12</sup> Examination of the opposite sex, particularly of female patients by male doctors, should ideally always be chaperoned. Unfortunately, the current shortage of nursing staff, the nonchalant attitude of some medical doctors, and the high degree of illiteracy in the country (which in turn makes most female patients oblivious of their basic rights) make this a counsel of perfection which it is almost impossible to observe.

### **Express Consent**

This may be oral or written. Oral consent may be necessary for minor investigations and procedures such as blood tests. It is advisable for a third party to be present so as to prevent subsequent denial by the patient especially in examinations involving the opposite sex. Written consent is necessary for more invasive procedures such as in the following:

- a. All Surgical procedures
- b. When carrying out invasive examinations
- c. When trying new or experimental methods
- d. When examining persons accused of committing a criminal offence.<sup>13</sup>

### **Consent in Special Cases**

**Children:** In cases of children below the age of 18 years (minors), the consent of their parents or guardians is required. In the case of children in legal institutions, a legal guardian, e.g. the principal of the school, may give consent “in loco parentis” in emergency situations.

**Married Couples:** For personal treatments, it is not necessary to seek the consent of the other spouse, except in cases where they both have interests as in family planning, tubal ligation, vasectomy or termination of pregnancy on medical grounds.<sup>14</sup>

**Emergency Situations:** In emergency situations, a medical practitioner may give all the care that is necessary to save life, but such major procedures as amputations must be with proper consent from relations, the patient or legal guardians.<sup>15</sup>

All in all, the express or implied agreement or consent between the doctor and the patient often gives rise to professional relationships.

The relationship involves mutual consent of the parties. Once a doctor-patient relationship is found to exist, the duty of care ordinarily demanded of a healthcare provider in relation to his or her patient arises by virtue of the law of tort independent of any contract between the parties. For this reason, the doctor’s job or duty is often viewed broadly as one based on professional medical relationship that may give rise in several contexts to obligations quite independent of any agreement between the parties.<sup>16</sup>

### **Consent in Medical Operations**

All medical operations, whether carried out under local or general anesthesia, or performed without anesthesia, have some morbidity and mortality risks. Efficient medical practice is based on

---

<sup>12</sup> -Mason, J.K. op. cit. 329

<sup>13</sup> - ibid

<sup>14</sup> -“ Abdulmumini. Op. cit. 103.

<sup>15</sup> - Ibid

<sup>16</sup> - Abdulmumini, op. cit. 103

accurate clinical judgment as to whether the risks outweigh the dangers or discomfort to the patient of withholding operation.<sup>17</sup>

Proper consent to operate is mandatory and must be of the informed type. This implies that the patient must be given sufficient information to enable him or her to make an autonomous decision as to the assumption of risk. There are, however, differences as to the extent of disclosure required. In the United States, where the principle of informed consent is heavily based on the patients “right”, there is an undoubted move to a “disclose all” policy.<sup>18</sup> Here, the patient is entitled to any and all information he wants and to any that the doctor is capable of imparting.

In the United Kingdom, the emphasis is more on maintaining the trusting relationship between the doctor and the patient, and the test is rather that the later should have such information as will enable him to make a rational decision.<sup>19</sup> Thus, the extent of necessary disclosure is proportional to the understanding of the patient, the questions he or she asks, the extent of the risk, the availability of alternatives, and any element of experimentation. The effect on the patient can be considered but it is important that any clinical reasons for withholding information should be adequately recorded. This last concession allows for a somewhat reduced obligation on the doctor if the treatment is necessary and is the only one available.<sup>20</sup>

In the United Kingdom, the patient’s consent, particularly to medicine, is, in general, specific to a stated intended course of action; whether an operation can be extended beyond that consented to, depends on the urgency and relevance to the primary treatment and on the additional effects of the secondary procedure. In recent times, it seems certain that a signature on a “blanket consent” form would not be regarded by the courts in Britain as adequate.

In Nigeria, even though the rules exist in principle, the degree of ignorance and illiteracy is such that patients are hardly aware of their rights as far as informed consent is concerned, thus virtually leaving the medical practitioners with unlimited liberty and privileges over the patients. Moreover, the fatalistic attitude of most Nigerians, who leave everything in the hands of God, does not help matters.

### **Consent in Medical Experimentation**

Some form of medical experimentation is essential if medical knowledge is to advance for the good of society. Much preliminary work can be done on animals, but ultimately it is the effect of the procedure on human beings in controlled circumstances that will determine its use in practice.<sup>21</sup> Experiments can be intended as treatment in an experimental fashion, they may be designed to increase academic knowledge, with little respect to the immediate practical application, or they may be needed to test the efficacy of an accepted treatment, or to study the spread of a disease. The subjects of this experimentation may be the researchers themselves, health volunteers, or patients, internationally accepted guidelines are detailed in the Declaration of Helsinki (1975)

---

<sup>17</sup> - Ibid

<sup>18</sup> - Anigbogu, I.E. Law and Professional Negligence by Surgeons in Nigeria. Jos, Dec. 2002. <sup>1</sup>(1) Mason, J.K. op. cit. 344

<sup>19</sup> - Sidaway, V. Bethlem Royal Hospital and Maiidslev Hospital H.A. and others (1985)2w. L.R.480.

<sup>20</sup> - Bolam v. Friern Barnet Hospital management Committee (1957) 1 W,K,K, 583

<sup>21</sup> - “Mason J.K. op. cit, -‘ Chatierton v Gerson (1981) 1 ALL E.R. 257

which emphasizes the distinction to be made between therapeutic and non-therapeutic experimentation.

Uncontrolled experimental treatment of the individual is ethical, provided there is no recognized alternative, or that the recognized treatments have failed and the patient is seriously ill. This situation should be thoroughly explained to the patient and informed consent obtained. If the treatment is painful or possibly liable to shorten life still further, then in this case, the additional consent of a spouse or a close relative would be necessary and desirable. The principles defining informed consent will mostly apply in these cases.<sup>22</sup>

***Consent in Assisted Reproduction Technologies:*** In assisted reproductive technologies such as artificial insemination with donor sperm, the concept assumes a wider dimension. Here, it becomes necessary to explain not only the procedure and any possible complications but also the socio-cultural and inheritance implications of using donated sperm to father a child.<sup>23</sup>

### **Consent in Blood Transfusion**

According to C.O. Okonkwo, members of the religious sect known as Jehovah's Witness object to blood transfusion as a matter of religious belief. If after explaining the pros and cons of a transfusion to a patient of the sect, it is refused by patient, a doctor is free to reject the patient. The doctor should not force a transfusion upon the patient otherwise the doctor may be liable for battery. On the other hand, if, despite the refusal of transfusion, a doctor decides to operate on such a patient knowing very well the probable risk of death, the doctor may be liable in negligence if the patient dies.<sup>24</sup>

### **NEGLIGENCE**

Medical Negligence in Nigeria has been on the increase; hence urgent need to address the problem in terms of the attitude towards medical practice and law regulating the practice, to ensure the protection of the patient on one hand, and make the physician liable on the other hand while serving punishment for any medical practitioner who, through carelessness causes permanent harm or death to a patient.<sup>25</sup>

In spite of all the axioms and principles of medical practice as laid down by the founders and fathers of medicine, most contemporary Doctors still fall short of expectations as far as negligence is concerned.

The law of tort defines negligence as "liability-producing conduct arising from the rendering of professional service" and since the professional service in question is medical, negligence here could be defined as liability – producing conduct, arising from the rendering of professional

---

<sup>22</sup> -Mason J.K. op. cit. 335 30

<sup>23</sup> -Ibid

<sup>24</sup> - Anigbogu, I. E. Artificial Insemination: Reproductive Law in Nigeria. Jos, 2006

Case for Legislation on Okonkwo, CO. "Medical Negligence and the Legal Implications in Nigeria:, Medical Practice and the Law in Nigeria, Umerah, B.C. cd, Longman Nig., 1987, 133. It is pertinent to note that where consent is refused, a medical practitioner is not entitled to give treatment even though it is in the interest of the patient. At the same time, he is not bound to reject or discharge the patient. Thus, a practitioner will not be liable in negligence for retaining a patient who refuses blood transfusion in a condition of severe anemia. See Medical and Dental 31

<sup>25</sup> - Okejie A.E. Medical practice and the Law of Negligence in Nigeria. Ambak Press LTD 2018.

medical service. In strict legal analysis as stated by **Lord Wright in local iron and coal company ltd. V. McMillan**<sup>26</sup>, negligence means, “More than heedless or careless conduct whether by omission or commission. It connotes a complex notion of duty, breach, and damage thereby suffered by the person to whom the duty was owing”.

In all circumstances of the case, the conduct of the defendant fell short in the given situation of the standard of care within the scope set by law. It was the defendant’s conduct that actually caused the damage, thus for the plaintiff to succeed in negligence he must prove:

- a. That the defendant owes him a legal duty to take care
- b. That the defendant breached that duty,
- c. That the damage, as was reasonably foreseeable, resulted from the breach of such duty to take care.

Equally, negligence as a tort could be viewed to consist of the breach of legal duty to take care, which results in damage undesired by the defendant to the plaintiff.<sup>27</sup>

Ordinarily, negligence could be defined as “a conduct which falls below the standard established by law for the protection of others against unreasonable risk or harm”.

Negligence may be either a mental element which is very technical tort, and which requires strict proof of the element constituting it, or it may connote an independent tort. The importance of negligence as a tortious liability in Nigeria today is underlined by the fact that since independence majority of case in torts in this country are in one form of negligence or the other. Most litigation in medicine and medical practice today are as a result of negligence.<sup>28</sup>

Professional negligence in the practice of medicine can only be proved on the establishment of the following facts:

- i. The existence of the Doctors duty to the plaintiff, based on the Doctor-patient relationship. That is to say, a fiducial relationship must be proved to have been established between the Doctor and the patient.
- ii. The applicable standard of care and its violation
- iii. A compensable injury.
- iv. Causal relation or connection between the violation of the standard of care and the harm or injury complained of.

There are some variations in the judicial decisions, statutes and the legal literature with the precise scope of the term “Negligence” some have tried to equate negligence solely with malpractice, as in **Kenny V Piedmont**.<sup>29</sup>

Torts principles have now largely taken the place of the law of contracts as the doctrine that defines professional medical liabilities. Current legal concepts governing the professional negligence of medical practitioners reflect a new awareness of the modern therapeutic potentials of modern medicine, and the heightened public expectation they inspire.

<sup>26</sup> (1934) A.C.1

<sup>27</sup> Rogers W.V.F (ed) Winifield and Jollowic3 on Tort. (13<sup>th</sup> edn..) p.72 (London: sweet & Maxwekk)22

<sup>28</sup> - Doctors; Deadly Errors: Patients; Tales of woes. The “source” magazine Vol. 30, No 6, Nov.28.2011

<sup>29</sup> Kenny V Pedomount hospital 1136 G.A. App 660,222 S.E 2<sup>nd</sup> 162 (1975)



However it must be noted, that provided he has executed reasonable skill and care a Doctor cannot be held negligent for a mistake in diagnosis. The classic authority for this is Lord Clyde who, when Lord President, stated thus “in the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion, and a man clearly is not negligent merely because his conclusion differs from that of the other professional men not because he has displayed less skill or knowledge than others should have shown”.<sup>30</sup> Thus it is clear that while an error in clinical judgment need not necessarily be negligence, it can only be so, if it is reached in a manner falling below the test standard,<sup>31</sup> the standard of the ordinary skilled man exercising and professing to have that skill.<sup>32</sup>

In the majority of professional negligence, liability will depend on direct evidence of conduct that falls below that level that the society allows, with impunity. Thus the mere fact that a patient suffered a health impairing experience during the course of medical procedure will not, without more, ordinarily render one providing medical service liable for negligence or malpractice.

### THE DOCTOR’S DUTY

Duty situations in torts are not confined to negligence alone because there is a general duty cast on persons not to commit any tort at all. However, it is in negligence that the notion of duty is of paramount importance apart from damage. Infact it is the concept of duty that is used by courts as a control mechanism to keep liability for negligence within bounds.

Accordingly, for the plaintiff to succeed in an action for negligence he must show that the circumstances from which the damage complained of arose are those capable of giving rise to duty of care. Apart from this, he must also show that such duty was actually owed him by the defendant (i.e. duty to act) breach of that duty, compensable damages and proximate cause.

There is a duty in the general sense and duty infact on the one hand, the question as to whether a circumstance is capable of giving rise to a notion of duty raises question of law, while on the other hand whether in a circumstance duty is actually owed to a particular plaintiff is a question of mixed fact and law.

The question that arises at the point is how are duty situations determined? This may be easily answered where there have been previous decisions. But where there are no precedents the judge is faced with an onerous task. The first attempt at formulating a general principle of duty was Brelt M.R., in the case of **Haven V Pender**,<sup>33</sup> when he said “whenever one person is by circumstances placed in such a position with regard to another that everyone of ordinary sense recognize that if he did not ordinary care and skill in his own conduct with regard to these circumstance, he would host danger of injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid danger.

However, the best and perhaps the most generalization is one by lord **Atkin in Donohue V Stephenson**<sup>34</sup>, where the principle of neighbourhood was one in question. The rule that you must

---

<sup>30</sup> In Hunter V. Hanlev 1955 S.L.T at P. 217 ( in Mason J.K. Forensic Medicine for lawyers 2<sup>nd</sup> edn. Butterworth and Co

<sup>31</sup> Whitehous V Jordan (1981) IALLE. R 267 Per Lord Davies

<sup>32</sup> -Chinkown. Government of Malasia (1967) WLR813

<sup>33</sup> - (1983) 11Q3D, 503 & 509

<sup>34</sup> - (1932\_ A.C 562

care for your neighbor becomes in law, you must not injure your neighbor, and the lawyer's question "who is my neighbor?" receives a restricted reply. You must take reasonable care, to avoid acts or omissions, which you can reasonably foresee would be likely to injure your neighbor. Who then, in law, is my neighbour? The answer is, "persons who are so closely and directly affected by my act that I ought reasonable to have them in contemplation as being so affected when I am directing my mind to the acts or omission which are called in question". In order for one to be held liable for medical or medical negligence, or malpractice, of any sort, it must first be established that the Doctor owed a duty of care to the injured party. This duty is one to perform and a concomitant duty to do so as in an acceptable manner. The existence of the medical personnel's duty is based on the legal obligations society imposes on a professional who undertakes to enter into such a relationship.

### **THE DOCTOR – PATIENT RELATIONSHIP**

The express or implied agreement between the Doctor and the patient often gives rise to their professional relationship. Therefore, the duty owed by the Doctor to the patient is sometimes perceived as one based on service contract. In most cases, the relationship involves the mutual consent or assent of the parties concerned. Once a Doctor – patient relationship is found to exist, the duty of care ordinarily demanded of a health care provider in the relationship is usually imposed by society through its tort laws rather than an incidence of any existing contract between the parties.

For this reason the Doctor's duty should be viewed as one broadly based on a Professional Medical Relationship that may give rise in several contexts and that may give rise to obligation independent of any agreement by the parties.

In the majority of malpractice cases, the plaintiff is the patient, the individual who received or should have received care or his survivor or legal representative.

Occasionally however a medical personal may be sued by a non-patient relationship with someone or from a special contract with the plaintiff.

### **TRADITIONAL PROFESSIONAL RELATIONSHIP**

The existence of Doctor-patient relationship is supported by two theories. The first of these theories is the contract theory, where the Doctor accepts to render services to a patient in exchange for specific fees.

Here, a contractual agreement is created with its attendant rights and responsibilities, where both parties each has a specific agreement, as to the terms of treatment, and an express contract may be said to have been formed.

An implied contract may also be created in that the court will infer, from surrounding circumstances such as the consent of the patient, and the link expectation of compensation for the Doctor.

A contract either expressed or implied is the most common source of patient-Doctor relationship. A situation may occasionally arise, which may not conveniently relate to the contractual condition narrated above. This is for instance, a situation where an unconscious patient is treated without his knowledge or express authorization, and by a Doctor previously unknown to him. This is common

in cases of Road Traffic Accident. Such services are often rendered gratuitously, without any promise or expectation of a fee. Purely an emergency act, to save life. A more workable theoretical basis that creates a Doctor-Patient relationship in such cases seems to be offered by a second theory. The theory holds that a Doctor who undertakes to render care to another creates a professional relationship with a corresponding duty of care to the patient. Liability may result from substantial care where one undertakes to render service which he should recognize are necessary to protect the safety of another. One who takes charge of mother who is helpless would recognize that he may be liable for bodily harm occasioned by his failure to exercise reasonable care to secure others' safety or by leaving the other in a worse situation or condition or position than before by discontinuing aid or treatment.

The doctor's duty of care may arise, as a result of an undertaking of treatment, even where the services are gratuitous and not based on a contract, and there is no expectation of payment. It must be noted however, that the mere fact that a Doctor is involved in the general practice of medicine or medicine, has not been held sufficient to subject him to respond to the call of any one in need, to aid and moreover, very little in the way of an undertaking may be required to establish a patient-Doctor relationship. Where a Doctor is assigned to treat a patient specifically an extreme example of Doctor-Patient relationship, based on undertaking theory arises. In such a situation, the Doctor is expected to know the full details of the patient's illness. In a situation where a patient is brought to the Doctor on duty, and he feels that the condition is not serious and patient therefore asked to go home till the next morning, if the patient subsequently dies the court would hold *inter alia* that there was a breach of duty on the part of the Doctor. But as in the case of "**Gillanaza V Sands**"<sup>35</sup>, where at no time had the physicians met the patient, examined her, diagnosed her condition nor had any contract with the patient nor her family, the court would hold that a notable issue of act existed, that no physician-patient relationship was created. In hospital cases, courts have been even willing to find it necessary to support the creation of Hospital-Patient relationship. Where there was a mere gratuitous promise for non-performance, even though the promise relied on the promisor to his detriment. A promise by a patient or a third party to pay for future services promised by a Doctor should certainly be adequate consideration to support a contract, which in turn would create a duty. In addition, when the Doctor's promise is made in a setting that would suggest an implied agreement to perform services in exchange for a fee, the courts seem to assume that a duty is created.

In **Maltempo V Curthberth**<sup>36</sup>, a physician promised to parents to look into the deteriorating condition of their diabetic son who was imprisoned, apparently creating a duty. Although there was no evidence that the physician had undertaken to perform by calling the jail or prison, the court did not rely on that as a base of duty but rather held that the parents had a right to rely on the physicians assurances. The courts have through the implied contract and undertaking theories, broadened the class of activities that may give rise to a physician/Doctor-patient relationship.

Nevertheless, there are limits to their willingness to find the existence of such relationship. In a decided case, a patient sued a medical school professor, who at a professional conference offered an opinion that medicine was indicated after hearing the patient's history. In upholding the

---

<sup>35</sup> 316S. 2d77 (fla App. 1975)

<sup>36</sup> - 504F.2d 325 (5<sup>th</sup> Cir 1974)

dismissal of malpractice case, the Appellate court held that there had been no physician-patient relationship between the professor and the patient.

The general test adopted by the court for deciding whether a duty existed in the absence of traditional Doctor-Patient Relationship involved a balancing of such factors as the extent to which the defendants action were intended to affect the patient the foreseeability of harm, the certainty of the patient's injury, the closeness of the condition between the defendants conduct and the injury suffered, the blame-worthiness of the defendant's conduct, the policy of preventing future harm, the kind of person with whom the defendant was dealing, the relative ability of the parties to adapt practical means of preventing injury, and the prophylactic effect of the rule of liability. In striking a balance in favour of the defendant, the court noted that he had no right to control the patient's treating physicians, and that the imposition of liability might tilt efforts aimed at disseminating medical knowledge as in the case of **Rainer V Grossman**<sup>37</sup>. The cases like that of Rainer are often dealt from a number of analytical perspectives. Some courts focus on questions of relationship and duty, while others seem to or rely upon the traditional doctrine of proximate cause.

### **PROFESSIONAL RELATIONSHIP: ITS LIMITATION AND TERMINATION**

Doctor-patient relationship is normally based on mutual relationship between the Doctor and the patient. It therefore follows that the doctor, (within the bounds permitted by public policy) is usually free to limit the scope of that relationship. A practitioner is at liberty to limit his office hours or consultation hours, and may adopt policies limiting or excluding house calls, at least in the absence of reasonable expectations of the patient to the contrary, or emergency.

A Doctor may also choose to limit or restrict the nature of his practice by specializing, and where consistent with sound medical practice, by refusing to perform certain types of medical or surgical procedures. It must be noted that unless such limitations are reasonably to be expected based upon common practice, or upon prior course of conduct of the Doctor, a Doctor should notify the patient in advance, of significant limitations on his practice. Should the patient's condition call for surgical procedure, and the Doctor does not choose to perform, he has an obligation to refer the patient to another Doctor for necessary treatment. Implied limitations are often also found in professional relationship. Although the Doctor may refuse to enter into a professional relationship with the patient, and may at the outset normally limit the scope of his professional involvement in a relationship, he does not otherwise have an unqualified right to terminate an existing relationship. The effect of the above is that unless limited by an express or implied understanding of the parties, the relationship cannot be terminated at the will of the Doctor unless treatment is no longer required, the relationship is terminated by the patient, or suitable notice is given that affords the patient a reasonable opportunity to engage the services of another Doctor. The patients' condition, the availability of another competent Doctor, the manner of the notice, and the patient's educational status are among the factors that determine the reasonableness of the notice, as was determined in the case of **Grace V Meyers**<sup>38</sup>. Provided a reasonable opportunity is afforded the patient to obtain another attending Doctor, or the patient dispenses personally with the services of the Doctor, the Doctor is theoretically free to withdraw from a case. In circumstances where treatment is already scheduled and the condition stipulated above are not met, the Doctor is liable on conviction to pay damages for breach of contract. Where statutes providing for voluntary

---

<sup>37</sup> 31 Cal. App. 3d 539.107 Cal. Rptr. 469 (1973)

<sup>38</sup> 224 N. C 165, 295. E 2d 553 (1994)

attribution of malpractice disputes state that the patient's agreement to submit to attribution is not a prerequisite to treatment, because such statutory provisions may suggest a potential limitation on the right of the Doctor to refuse to enter into a Doctor Patient relationship, or to terminate an existing relationship, where the relationship is unilaterally terminated, prematurely terminated, or disregarded by the Doctor without reasonable notice, the Doctor is liable for abandonment of the plaintiff (patient) as in the case of **Baulsir V Sugar**<sup>39</sup>.

The proof of abandonment is not as rigorous as in malpractice. It is common in practice that the courts tend to lump together situations involving negligent failure to diligently follow a patient with the traditional abandonment cases. All the same, there is a distinction between negligence and abandonment. This distinction manifests in the fact that in negligence, expert testimony as to standard of care is required, while in intentional abandonment, the mere fact of termination may establish the defendant's fault. Sometimes a patient may fail to pay, or may refuse to co-operate in treatment. Such action may not relieve a Doctor who without reasonable notice abandons or negligently fails to attend to a patient. Above situation is particularly true when the patient's conduct does not become so obstinate as to defeat the efficacy of the treatment, or constitute a withholding of consent of treatment. Notice should be taken of the fact that the selection of a competent substitute Doctor to care for the patient may not prevent liability for abandonment, particularly if damages proximately result therein, and it is proved that notice was not given in sufficient time to enable the patient to engage a Doctor of choice. This was the case in **Miller V Dore**<sup>40</sup> where a patient decided to postpone medicine until the return of her original physician. Referrals from one Doctor to another competent or specialized Doctor is a common, allowed, and indeed laudable occurrence in medical practice.

Therefore, where a patient is referred by one Doctor to another competent Doctor, there will generally be no liability where the patient's condition reasonably appears to warrant such a referral, and the patient is duly informed. This is particularly safe, when it is the considered professional opinion of Doctor that the patient will benefit more from such a referral.

### **Euthanasia**

It is a befitting tribute to the medical scientists that over the years, remarkable and breath taking developments have been recorded in many areas of human health. Evidence of these commendable developments can be seen in Artificial insemination, In-Vitro fertilization, Surrogate motherhood, sex detection and selection,<sup>41</sup> and now, cryonics.

As a result of the galloping advances in biotechnology, reproductive biology, nanotechnology and nanomedicine, exotic machines and medicaments have been developed, which have been vital in extending patients lives.

In the words of Pozard, "*Advances in medicine and related technologies that have resulted from human creativity and ingenuity have given society the power to prolong life. The process of dying also can be prolonged*".<sup>42</sup>

---

<sup>39</sup> 266 Md, 390, 293A 2d 253 (1973)

<sup>40</sup> 154Me 363, 148A 2d 692 (1959)

<sup>41</sup> J.A. Dada, "Legal Aspects of Medicine Practice in Nigeria 2<sup>nd</sup> Ed. University of Calaba Press 2013 PP. 273 - 282

<sup>42</sup> Ibid

Edmund Leach in the same vein maintains that the frontiers of biotechnology can now alter the course of nature, prolong life, and bestow prospects of comfort on an otherwise hopeless prospect.<sup>43</sup>

These can hardly be said of Euthanasia which is medically defined as a quiet, painless death, the intentional putting to death by artificial means of a person with incurable painful disease, the act of killing someone i.e a patient, painlessly in order to relieve the person from suffering or pain due to an incurable or terminal disease. Human life is a gift from God and no human being or organization or establishment should have any right to terminate it, except God himself.

Euthanasia is pessimistic and portrays the healthcare providers as lacking in compassion and patience, considering the permanence and irreversibility of death. Medical practice is basically dependent on science and scientific innovations. In euthanasia, healthcare providers seem to have lost faith in science that is the very *raison d'être* of medicine. It is like dynamic science closing the door against itself, since it seems to foreclose the possibility of a cure being imminently discovered.

Euthanasia is killing, no matter what colouration or interpretation it is given, and God's injunction is specific "thou shall not kill".

The question of helping the patients is untenable. One cannot help a patient by killing him. Indeed Euthanasia is intrinsically and morally wrong no matter how it might help the patient. Placed at the disposal of unscrupulous healthcare providers euthanasia could become a disastrous instrument.

Euthanasia runs against the natural law of self preservation. With Euthanasia the absolute trust which a patient should have, that the physician would save him by all means is thoroughly shaken.

The golden rule of medical practice is "*primum non nocere*" at least do no harm. With euthanasia, this golden rule is broken.

### **Conclusion**

It must be indicated that medico-legal ethics is a very wide discipline, and this presentation has only but attempted to deal with the proverbial tip of the iceberg. It is unfortunate, that observation has elicited that this all important discipline is not accorded as important to an underestimation of the role of medico-legal ethics in the colouring of medical practice. It is also possible that it could be attributable to simple paucity of the knowledge of same and/or shortage of man power.

### **Recommendations**

It is being humbly recommended that:

1. The scope of the study of medico-legal ethics be expanded.
2. The study of forensic medicine be introduced in the medical curriculum of all faculties formed in the universities and be made compulsory.

---

<sup>43</sup> Ibid

3. That law be taught in all medical schools at least up to diploma level.
4. While teaching law in the medical schools as suggested above, special emphasis be laid on such areas as:
  - a. Law of Contract.
  - b. Law of Torts.
  - c. Reproductive and health Care Law
  - d. Jurisprudence and Bioethics.