DEVELOPING AN INTERNATIONAL LEGAL FRAMEWORK TO REGULATE AND REDRESS MEDICAL NEGLIGENCE*

Abstract

Regulating medical practice and redressing medical negligence are usually in the purview of each nation state. *However, medical treatment has over time migrated from the confines of domestic arena to global stage. To this effect, there is a need to have a universal minimum standard of regulation that will serve as base line for global governance from which all domestic orders draw from. This becomes crucial because of emerging realities of medical tourism and international travels among others. This paper, using the doctrinal research method, interrogates the existence of any international framework or mechanism regulating and redressing medical negligence, it reviews the need, sufficiency or otherwise of these standards. It also distinguishes the existence, relevance and limits of international self-regulatory institutions and extant laws to the public international law. It further examines the various international regulatory bodies and laws presently in place, with regards to self-regulatory and the public international structures. The paper ends by exposing issues and challenges posed by self-regulatory structures which underscores the expediency of a global unified process that will moderate, challenge as well as harmonize the minimum standard of redress structures of all nations to safeguard the trust of humanity in the medical practice.*

Keywords: International Legal Framework, Redress, Regulate, Medical Negligence

1. Introduction

Seeking redress for certain private wrongs such as medical negligence falls within the clout of each independent nation. Every country has created its own system of accessing redress and compensation for victims of medical negligence. However, the need for international standards in most areas of life is becoming pronounced each day, especially with more interactions between the international and municipal laws and courts.[1] Globalization has increased the porosity of domestic legal orders, while at the same time it has led to a considerable swell in International regulations. It is only natural then that domestic courts would be faced ever more frequently with having to apply rules promulgated at the international level.[2] Therefore it is becoming of utmost important that an international mechanism should be created that will regulate and standardize medical practice, this international structure will consequently dispense into municipal law arena. Added to this is the fact that medicine is both a developing and interactive skill, particularly now that the world has become a global village. There is the exchange of ideas and knowledge worldwide, as new frontiers are being discovered in a jurisdiction, the knowledge is shared globally in order to better the lot of humanity.[3] Therefore, a skill of such necessity must be regulated to avoid untoward consequences that may arise from individualism. Also, the need for a unified standard of redress for medical negligence is essential in balancing the existing disparity that exist in different jurisdictions, that is, over-regulations and under-regulation because law can be both aspirational and constrictive. In developing jurisdictions, international law becomes aspirational while it could be restrictive to developed nations where there is the prevalence of defensive medicine. International standard of redress serves as restrictive mechanism that will balance the overzealousness of patients. Further, since patients subject themselves to the care of the physician not only because there is the assumption that the physician is skilled in the area of practice, but also that there exists the trust that his skill and practice is well guarded, monitored and regulated by a 'superior' power. If this be the case, then there is the onus on the world to ensure that the physician is not careless, shrewd or out rightly dangerous, that he is not excessive in the use of his medical might and not subjecting every patient to his whims and caprices; or if injury should occur to a patient as a result of the carelessness of the Healthcare professional, the world ought to create a system that will moderate as well as unify the redress structure of all nations so as to safeguard the trust of humanity in the medical practice. Essentially, there should be a global minimum standard of redress which ought to form the bedrock of each domestic law.

Consequently, the aim of this paper is to examine if there exist any redress regulatory framework for victims of medical negligence on the international vista; it inquires whether there is an international standard forming global

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[1] A. Tzanakopoulos & C. J. Tams, 'Introduction: Domestic Courts as Agents of Development of International Law' [2013](26)(3) *Leiden Journal of International Law*; 531-540.

[2] A. Tzanakopoulos, 'Domestic Courts in International Law: the International Judicial Function of National Courts' [2011] (34) *Loyola of Los Angeles International & Comparative Law Review* 133 – 168; W. Ruddick, 'Doctors Rights and Work' [1979] (4)(2) *J Med Philos*; 192-203.

[3] A. B. Ramírez de Arellano, 'Patients without borders: the emergence of medical tourism' [2007] (37(1) *Int J Health Serv*; 193-8.

redress structure, and what mechanism is set up to monitor these standards; it reviews the sufficiency or otherwise of these standards and mechanism. It also distinguishes the existence, relevance and limit of international self-regulatory institutions and laws to the public international law. To achieve this aim, the paper is will inquire whether there is a need for any international legal framework and of what benefit will the existence of an international mechanism be to municipal laws. The paper finally ends by bringing out the issues and challenges posed by the earlier parts and proffer certain recommendations. It should be noted that this proposal is not based (primarily) on the failure or success of municipal laws to address Medical Negligence but because medical practice like many aspects of life, has grown beyond the local ambit.

2. Need for International Legal Framework

Medical law and practice unlike other aspects of humanity such as rights, labour and economy is still fundamentally in the domain of each countries of the world. There is a lack of global uniformity in redress structure, each nation creates and runs its own structure notwithstanding the aptness of such structure. But as the world is becoming smaller by the day and a lot of interactions take place, which is assisted by the incursion of information technology and other technological advancement there is need for uniformity of redress standards and structures. More particularly is the increase of persons travelling to other countries solely to achieve health and wellbeing.[4] This practice is fuelled by various reasons ranging from shortage of expertise in the home country, political factors, and socio-cultural attitude of people in the upper echelon of the society. Yet a lot of ethical and regulatory issues are attached to medical tourism.[5] When an untoward incidence occurs to such medical tourist in the destination country traceable to the negligence of the healthcare professional, redress options available to such medical tourist is often unclear. Regulatory issue is perhaps one of the biggest challenges of medical tourism, as there is no unified and well-articulated legal framework that monitors, control, standardise, and regulate the health care system globally. Usually an unsatisfied client may sue either in negligence or in contract, and a lot of jurisdictions across the globe require that fault be proven but, in this situation, there is no international regulatory framework of medical tourism and no set of standards of care and treatment which can be applied to every type of operation.[6] Further, is the conflicts of law problem (issues of jurisdictions), the appropriate forum to bring litigation. Hospitals that provide foreign services habitually insert the jurisdictional clauses in their contract for treatment which makes the courts of that country the appropriate forum to try such matters. Added to this is the question of the applicable laws, enforcement of judgement, even if and when the issue of the appropriate forum is sorted out, the emotional and financial requirement often needed to prosecute such cases are very demanding on the patient. Countries like UK and other European Union have the legal framework to answer some of these questions, but this is very novel to a lot of African nations who are still battling with a number of domestic problems that are unrelated to medical tourism. Related to medical tourism is the international patients. This concept though similar with medical tourism differs fundamentally; an international patient happens to take medical treatment in another country by virtue of the fact that the incidence of ill health occurred to him while he is on international travels which he underwent for another purpose.[7] Therefore such categories of international patients could include holiday makers, business travellers, non-nationals who are residents but not citizens of the country, temporary expatriates, long tern expatriates, oversee students.

Another factor which makes an international legal framework essential is the intertwine of human rights and medicine. Human right finds a fertile soil in medicine to display its essence by protecting the rights of the patients. It emancipates the patients from the paternalistic hold which healthcare professionals have had over patients.[8] Rights protects includes: right to life; a patient has a right to live, *simpliciter*.[9] Patients also have the right to consent (autonomy); every human being has a right to determine what should be done or what should not be done

[4] D. York, 'Medical tourism: the trend toward outsourcing medical procedures to foreign countries' [2008] (28)(2). *Journal of Continuing Education in the Health Professions;* 99-102.

[5] M Helble, 'The movement of patients across borders: challenges and opportunities for public health' [2010] (89) <*WHO .int. bulletin volume*> accessed 10 May 2020.

[6] *Ibid.*

[7] J. Snyder and others, 'Understanding the Impacts of Medical Tourism on Health Human Resources in Barbados: A Prospective, Qualitative study of Stakeholder Perceptions' [2013] (12)(2) *Int J Equity Health*; L. Bertinato and others 'Policy brief cross-border health care in Europe. World Health Organization, Brussels' [2005] <http://www.euro.who.int/__data/assets/pdf_file/0006/108960/E87922.pdf> accessed 23 May, 2020.

[8] A. Garwood-Gowers & J. Tingle, 'The Human Rights Acts 1998: A Potent Tool for changing healthcare law and practice', in A. Garwood-Gowers and others (eds), *Healthcare Law: The Impact of the Human Rights Act.* (Cavendish 2001).

[9] Jonathan Herring, *Medical Law and Ethics* (Oxford University Press 2001) 40; R *(on the application of Pretty) v DPP* (2002) 1 All ER 1 at para 96, *Airedale NHS Trust v Bland* (1993) 1 All ER 821 at 880, 885 and 899.

to and on his body, a right to freedom of action and decision on the cause he is to pursue in any medical action.[10] Beauchamp and McCullough describe this as the right to self-determination.[11] Judge Cardozo's opinion in the case of *Schloendorff* v *New York Hospital*[12] reflects this principle that 'every human being of adult years and sound mind has a right to determine what shall be done with his own body'. Further, patients have the right to dignity.[13]All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood. Herring discussed this right using Roger Brownsword's discussion on the right to dignity.[14] In the case of *R(Pretty)* v *DPP*, the European Court of Human Right held that the very essence of the Convention is respect for human dignity and human freedom. The court further held that the law supposed to ensure that people who are vulnerable, were not taken advantage of by others nor manipulated into ending their lives.

3. How Domestic Laws Can Benefit from International Mechanism

The role and impact of international laws in national law differs and varies, the two sets of laws are essentially different bodies of laws which some scholars have referred to as separate braches of laws from the same tree.[15] Anthea Roberts,[16] restated the observation of Lord Bingham of the House of Lords in UK when he observed that:

> Times have changed. To the extent almost unimaginable …. national courts in this and other countries are called upon to consider and resolve issues turning on the correct understanding and application of international law, not on occasional basis, now and then, but routinely, and often in cases of great importance.[17]

There have been such interactions between international laws and the domestic courts and conversely between international courts and domestic laws. The domestic courts sometimes draw from the international laws and decisions in arriving at its own decisions hence getting it right at the international arena is of uttermost importance.[18] The subject matter of international law are said to be states (though at times or occasionally they include international organisations) while municipal or national law embraces individuals and the host of private associations.[19] However it is possible for national laws to adopt rules of international laws either by customs or by statute as part of the laws of its nation states. Over the years, international laws have come to play great roles in our legal system. There are several ways in which each nations internalise or domesticate rules of international laws; some by treaties, customs, and even statutes. Some nations even transpose such international laws through a domestic implementing act.[20] The class of customary international law which is referred to as *jus cogens* has peremptory force and cannot be abrogated by domestic law or treaty. These are set of laws generally deemed self-executing. States that are not parties to relevant human rights treaties generally accepts standards of human rights as legally binding upon them according to customary international law. In United States for example, except the court deems that a treaty is self-executing, such treaty cannot bind domestic courts until and except the Congress has passed legislation for the specific purpose of implementing such provisions of the treaty domestically.[21] However, in the case of *Filartiga* v *Pena Irala,*[22] a new trend was heralded when the court tilted towards the

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[10] *ibid*; *Schloendorff* v *New York Hospital* (1914) 105 NE 92.

[11] T.L. Beauchamp, and Laurence B. McCullough, *Medical Ethics,* (Englewood Cliffs: Prentice Hall 1984); M. Stauch, K. Wheat, J. Tingle, *Source Book on Medical Law* (Cavendish Publishing Limited, 1998). 30.

[12] (1914) 105 NE 92.

[13] The Preamble and Article 1 UDHR 1948.

[14] note 9, p. 14 – 15 ; R. Brownsword 'Bioethics Today, Bioethics Tomorrow: Stem Cell Research and the 'Dignitarian Alliance' [2003] (17) *Notre Dame Journal of Law, Ethics and Public Policy*, 15 – 51 at 26 ; D. Beyleveld and R Browsword, *Human Dignity in bioethics and Biolaw*. (Oxford University Press 2001.

[15] S. M. Myres, 'The Impact of International Law upon National Law: A Policy-Oriented Perspective' [1959] *Faculty Scholarship Series.* Paper 2614.< http://digitalcommons.law.yale.edu/fss_papers/2614>accessed 20th November, 2019).

[16] 'Comparative international Law, The role of national courts in creating and enforcing international law' January 2011, *ICLQ* vol. pp 57 -92.

[17] Lord Bingham, writing the 'Forward' in *Using International Law in Domestic Courts,* S. Fatima, (Hart Publishing, Oxford, 2005).

[18] R. Jennings, 'The Judiciary, International and National law, and the Development of International Law' [1996](1) 45 *ICLQ* 1, 1-4 ; *R* v *Bow Street Metropolitan Stipendiary Magistrate Ex parte Pinochet Ugarte* (No 3) (2000) AC. 147.) (*International Law Decisions in National Courts* Transnational Publishers, New York, 1996); H. Schermers, 'The Role of Domestic Courts in Effectuating International Law' [1990] (3) *Leiden J. Intl L.* 77- 79.

[19] Note 15 .

[20] Note 2

[21] 'Compilation of International Norms and Standards Relating To Disability', Part I. National Frameworks. 2/5 <http://www.un.org/esa/socdev/enable/discom101.htm> accessed 10 September, 2019.

[22] 630 F. 2d 876, 89 (2d Cir.1980).

domestic incorporation of customary international law. In that case the court recognised that the law of the nations is a 'dynamic concept, which should be construed in accordance with the current customs and usages of civilised nations'.[23] The court clarified two basic issues in this case; one, that customary international law is a matter of universal jurisdiction, so that any nation courts may hear extra-territorial claims brought under international law. And the second one is that domestic courts may discover international legal principles by consulting executive, legislative and judicial precedents, international agreements, the recorded expertise of jurist and commentators, and other similar sources.[24] Further in United States, in *Paquete Habana,*[25] the court restated the status of customary international law and held that it is part of the United State Law, and must be ascertained and administered by the courts of justice of appropriate jurisdictions as often as question of right depending upon it are duly presented for determination.[26] The United States bases for directly incorporating international human rights norms into U.S laws is that these international norms are binding as customary international or *jus cogens.* According to Article 38 of the Statute of the International Court of Justice,[27] the sources of international law include; International Conventions, International customs, General principles of laws recognised by civilised nations and judicial decision and the teachings of the most highly qualified publicists of the various nations as subsidiary. Though treaties are quicker and clearer mode of law-making in international law compared with the others.[28] However, the present system in which international law operates, remains largely consensual and is sovereign states centred unlike the pre-Westphalia era of subjugation through war.[29] This means that participation of each states is still highly discretionary either in negotiation, ratification or/and domestication. International law inter-relates with national laws and often has effect on the local laws and structures of law and legal institutions within the state. And this is one of the main concerns of this paper to see the extent the international laws, regulations and institutions (in the area of medical practice and/or negligence) has been able to shape and influence the Nigerian situation positively and if there are learning points from the international arena to correct some of the anomalies that may be present in our Nigerian's system. ICJ reaffirmed the principle of primacy of international law over national law and stated that the principle of primacy of international law over national law before international tribunals applies to all aspects of a state's municipal law.[30] Therefore, the rules of International law are enforced before the International Courts and Tribunals without considerations given to conflicting provisions or States Laws. However, 'conflicts between a state's municipal law and its international obligations do not affect the effectiveness of that law within the territory of the state'. [31] This means that where a municipal act of the state is contrary to international law, international law cannot invalidate such act or its domestic application affected by international law. Though when such internationally unlawful act (but municipally lawful) it may be denied of external effect by other states.

Internationals treaties seldom stipulate how each nations should implement or effect its provisions, these are issues left to the discretion of each nations, (though one exceptions to this is the right of access and to effective remedies guaranteed in human rights treaties). Each nation has the freedom to choose method of implementation and effecting international law is guaranteed by Article 2 of the International Covenant on Civil and Political Rights. Some countries give treaties or customary international laws constitutional status superior to national legislations.[32] There are two schools of thought on how international laws should interact with national laws. They are the dualist and the monists.[33] The dualist, which is based on the transformation theory posits that international law and national laws as separate and national law can apply only when it has been transformed into

[23] *ibid.*
[24] Note 22.
[25] 175 U.S. 677, 20 S.Ct.290.
[26] *ibid.*
[27] H. C. Gutteridge 'The Meaning and Scope of Article 38 (1) (c) of the Statute of the International Court of Justice' (1952), Transactions of the Grotius Society (Published by: Cambridge University Press on behalf of the British Institute of International and Comparative Law) 125 of 125-134. This paper is adopting this as the sources of International Laws.
[28] Treaties may be known by variety of names which includes Conventions, International Agreements, Packs, Standards Charters, Declarations and Covenants. Ahmad A.I. 'Ratification of treaties: the Role of the Legislature' [2013] A Paper presented at the African Legislative Summit held at the International Conference Centre Abuja; Malcom Shaw, *International Law* (Cambridge University Press) 74.
[29] *ibid.*
[30] The International Court of Justice in its Advisory opinion in the United Nations Headquarters Agreement Case 1988. This includes the Constitutional provisions of states to its ordinary legislation and to the decision of its courts. Ahmed note 28.
[31] *ibid.*
[32] For example, see Article 65 of the Dutch Constitution, Article 25 of the Basic Law of the Federal Republic of Germany, Article 10 of the Italian Constitution 1947.
[33] U.O Umozurike, *Introduction to International Law*, (Spectrum Books Limited, 1993).

national laws. This transformation can be either through the legislative, judicial or other political and statutory means recognised by the constitution of that nation.[34] Therefore, international law will not *exproprio vigour* apply in municipal sphere unless it has undergone the process of transformation by which it is admitted into the municipal corpus of law.[35] The dualist posits further that the act of 'transforming could be direct incorporation of the treaty provisions by means of a Schedule to the Constitution of a party state; or incorporation of some or the whole of the treaty into the provisions of the law of a state party. It can also be an enactment of some of the treaty provisions in one or more local legislation or enactment of the treaty provision as a whole by means of an Enforcement and Ratification Acts.[36] The monist, w ich is referred to as the incorporation theory, on the other hand believes that international law and municipal law are part of a single legal system.[37] It posits that international law is automatically part of the municipal law without necessity of domestication or any constitutional ratification procedure,[38] it sees national law as subservient to international law. This means that once accepted, a treaty in a monist jurisdiction is looked upon by all government bodies including courts or law within that state as a source of law.[39] Nigeria embraces the dualist or transformation theory, as it can be found in section 1(1) of the Constitution which affirms the supremacy of the Constitution over all laws and nullifies any law which is inconsistent with the provisions therein. The Constitutional provision which relates to domestication of treaties is found in section 12(1) of the Nigerian Constitution, and it provides thus: 'No treaty between the Federation and any other country shall have the force of law except to the extent to which any such treaty has been enacted into law by the National Assembly'.

Oyebode, opines that there are two ways in which domestication can be done; by re-enactment or by reference.[40] Transformation by re-enactment, also known as the force of law technique is used when the implementing statute directly enacts specific provisions or the entire treaty usually in the form of a schedule in the statute.[41] The other method is when the implementing statute transforms the treaty into domestic or municipal law merely by reference to the treaty generally, either through preamble, in the long or short title or the schedule of the domestic law.[42] The Nigerian position was further affirmed in the *locus classicus* on this discussion, the case of *Abacha* v *Fawehinmi.*[43] The Supreme Court held in this case that the domestication of a treaty by the National Assembly is essential for it to become enforceable and that once the treaty has been domesticated, the legislation incorporating the treaty enjoys superior hierarchy over non-treaty legislation. In some other cases, the court reiterates this position one of which is *Medical Health worker Union of Nigeria* v *Minister of Labour and Productivity,*[44] the Court held that based on the decision of *Abacha* v *Fawehinmi*,[45] the International Labour Organisation Convention though ratified by Nigeria, has not been domesticated, thus it is inapplicable in Nigeria. But in *Kehinde* v *Ojo Oyetunde*[46] the Court of Appeal qualified the extent of domestication by stating that the right to fair hearing and right to appeal as contained in the African Charter, would not trump the provisions of the Constitution limiting the time within which such cases or appeal can be brought.[47]

However, there was a watershed in this position via the Constitution of the Federal Republic of Nigeria (Third Alteration) Act 2010, which in Section 254(c)(2) holds that:

> Notwithstanding anything to the contrary in this Constitution the National Industrial Court shall have the jurisdiction and power to deal with any matter connected with or pertaining to the

[34] M. Shaw, note 28.

[35] B. Atilola 'National Industrial Court and Jurisdiction over International Labour Treaties under the Third Alteration', cited in F. A. Onomrerhinor, 'A Re-Examination of The Requirement of Domestication of Treaties In Nigeria' [2016] *NAUJILJ.*

[36] A. I. Ahmed, note 28.

[37] *ibid*.

[38] Blackstone's Commentaries on the Laws of England Book the Fourth - Chapter the Fifth : Of Offences Against the Law of Nation

[39] Ahmed, Supra note 28.

[40] Akin Oyebode, 'Treaty Making and Treaty Implementation in Nigeria: An Appraisal, (being an unpublished D. Jur. Dissertation, Osgoode Hall Law School, York University, Toronto, Canada. 1988).

[41] *ibid.*

[42] *ibid*.

[43] (2001) 4 SCNJ 400.

[44] (2004) NWLR (pt 953) 1, 23-24.

[45] (2000) 6 NWLR (Pt. 660) p. 228; 153,.

[46] Suit No. : CA/EK/EPT/1/2012, 30th day of November, 2012.

[47] Time limit of which is 60 days. Ahmad A.I. note 28.

> application of any international convention, treaty or protocol of which Nigeria has ratified relating to labour, employment, workplace, industrial relations or matters connected therewith.[48]

Amongst the provisions of this Act, the one relevant to this paper is the provision that enables as far as international labour standards, Conventions or Treaties is concerned, the constitutional requirement that such shall have the force of law even when it has not been enacted into law by the National Assembly. However, this is applicable only to international treaties and conventions that pertain to labour, employment workplace or industrial relations. This development, in the view of this paper is a positive one which should not stop or be limited to this area of living. There is the need for other and further amendments in our constitution which will allow the application some international treaties and Conventions without the domestication by the National Assembly. If there is in existence international treaties on human health, it should be accorded the status which the international Labour law has attained in our Constitution.

4. Existing International Regulatory Structures

A large number of existing professional bodies are self-regulatory and this makes their scope and efficiency limited because membership is not mandatory and no enforcement mechanism. Such bodies include: The World Medical Association: (WMA), The World Health Professionals Alliances (WHPA), International Council of Nurses (ICN), International Pharmacist Federation (FIP) and the World Health Organisation. It appears that the World Health Organisation which is an arm of the United Nations Organisation is actually the only public international organ that is not professionally based. Some of the instruments are – International Code of Medical Ethic (WMA), The Declaration of Geneva- (World Medical Association 1948, 1968, 1983), Declaration of Tokyo (WMA 1975), Declaration of Helsinki, Nuremberg Code. Resolution of Physician Participation in Capital Punishment (WMA 1981), Regulation in Times of Armed Conflicts (WMA 1956, 1957, 1983), Psychiatrists – The Declaration of Hawaii (World Psychiatric Association 1977, 1983), The Role of Nurses in the Care of Detainee and Prisoners (I CN),[49] Other indirect instruments are Codes, Conventions and Charters which are domiciled in other areas of law and humanity but have point of intersects with medical ethics and regulations. Part of which include:

- Psychologists – Statement by the International Union of Psychological Science (July 1976).
- Codes and Statements of the United Nations – Principles of Medical Ethic (United nations 1982)
- Declaration of Amnesty International – Amnesty International Declaration on the Participation of Doctors in the Death Penalty.
- United Nations Charter on Human Rights 1948
- African Charter on Human and Peoples Rights
- Standard Minimum Rules for the Treatment of Prisoners and Related Recommendations (United nations 1955, 1977)
- Amnesty International Conference on the Abolition of the Death Penalty (Declaration of Stockholm (11th December 1977)
- Convention for the Amelioration of the Condition of the wounded in Arm in the Field.

5. Matters Arising

Having examined various international bodies, organisations, documents, laws and policies which regulate and monitor medical practice globally, organs and instruments which promote good medical practice, save-guard patients' wellbeing, ensure their rights and create redress for medical negligence; there appears to be enormous lapses and inadequacies in the body of organisations which have not addressed medical negligence at the international level. The aims and objectives of forming most of these organisations direct its missions and achievements; it is obvious therefore that none was formed to create redress regime for medical negligence. However, some of these bodies and organisations have been able to move laws and ethics further through the promotion of their ideals, standards and principle though unable to create an international redress structure. Below therefore, an examination of both their lapses and strong points will be discussed.

(i). Presently, the International organisations examined in this paper appear to create standards but not necessarily regulations, they create quality assurance and not necessarily quality control: 'Regulation is a word that usually

[48] K. I. Amadi, 'Reflections on the Status of the National Industrial Courts under the Constitution (Third Alteration) Act 2010' [2011](5)(1), *Labour Review (NJLIR)*1.

[49] Other related ICN Position includes- 'Nurses and Human Rights'.· 'Rights of Children· Nuclear war'· 'Torture, Death Penalty and participation by Nurses in Executions'. See International Committee of the Red Cross, Rights and Duties of Nurses under the Geneva Convention of August 12, 1949, Geneva ICRC, 1970. International Council of Nurses, Code for Nurses, Geneva, ICN, adopted 1973, and reaffirmed in 1989.

brings doctors out in a rash'.[50] As seen above each of these bodies seems to be a standard creating bodies or organisations rather than actual regulatory bodies. There is a whole lot of difference between creating standards and actually regulating, though the two concepts find point of intersects. Standards are levels or quality of attainment required, they are model in comparative evaluations,[51] while regulations create rules, policies or directive which usually are maintained by an authority in prescribed mode.[52] Regulation creates restrictions and control, it gives areas of operation and refrains in medical practice. This is unlike standards which are only models of evaluations. Regulations are highly essential and needful in every cause. The reasons for regulations usually entail what Otto Doering referrers to as 'externalities'.[53] Externalities exists when life, welfare and wellbeing of another person or group of persons depends directly not only on his/her activities but also on activities under the control of some other persons or group of persons.[54] Quality can be achieved through the combinations of standards and regulation. Creating standards alone is not enough because standards are developed to describe the expectations for professional practice of medicine.[55] It stated further that standard describes what professionals are accountable and responsible for in practice, it represents performance criteria that can be used to interpret the scope of practice to the public. Hence standards cannot assume the role of regulation, because sanctions follows regulations or the break of regulations while standards do not necessarily carries sanctions.[56] 'The usefulness of regulatory system centres on its power to take appropriate action to protect the public when doctors fail to meet the standard expected of them.[57] Medical regulation concerns the development and maintenance of public trust.[58] Presently it appears that the global bodies are mostly standardising bodies rather than regulatory based on the fact that they all carry little or no sanctions. A very vivid example is the World Health Organisation, whose roles and function in the international arena seems to be normative and standard setting. It creates technical assistance and information to its member states and act as knowledge broker. It further often acts as funders to projects within the member states.[59] This paper is not condemning nor castigating these entire roles neither is it denying the fact that these roles are highly essential in creating a healthy world, but burden and benefit goes together. There should be an international system in place to regulate the activities of the healthcare professionals who have the final touch and interface with the people who are beneficiaries of all the aims and objectives of these international bodies and organisations. This is not also to create fearful health care givers who goes around looking over their head for the hangman's cold hand, rather it is to create a scenario as stated by Rizo that : 'in sum, we want doctors to be happy and healthy, caring and competent, and good travel companions for people through the journey we call life'.[60] Regulation according to Elinor Thompson, involves three pillars or regulatory functions, the first is to set standards, secondly, monitoring activities against those standards and lastly intervening to ensure that standards are maintained and where they are not, to apply sanctions.[61]

(ii). Most of the international organisations and bodies discussed in this paper dwell more on preventive healthcare and are more concerned with large number health issue than individual patient's welfare; they appear wholesale (general) rather than retail(specific). Many of these bodies give assistance rather than regulate. They seem to be treatment focused rather than practice focused. Substantive medical practice rather than procedural issue is more at the core of a lot of organisations. It also appears that these organisations are not addressing the reality that law in forms of right, civility, autonomy etc. exist within medicine. Therefore, the bodies are more 'medical standard' focus than 'patient's right' focused.

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[50] E. Thompson, *Understanding Medical Regulation A guide to good practice to develop a global partnership for development* [2005] https://www.mdgmonitor.org/mdg-8-develop-a-global-partnership-for-development/accessed 6 June 2020.

[51] Note 15.

[52] *ibid.*

[53] O. Doering, 'When, How, and Why Do We Regulate' [2002] <https://www.samedical.org/drs-patients-rights.html>. accessed 10 January, 2020.

[54] *ibid.*

[55] College of Medical Radiation Technologist in Ontario, Medical Directives and Delegation guide 2012 Annual Report.

[56] *ibid.*

[57] Note 15

[58] *ibid.*

[59] C. Clift, 'The Role of the World Health Organization in the International System' in *Centre on Global Health Security Working Group Papers* [2013]. (The Royal Institute of International Affairs). <www.chathamhouse.org> accessed 7 May 2020.

[60] C. A. Rizo, A.R. Jadad, M. Enkin, 'What's a Good Doctor and How Do You Make One?: Doctors should be Good Companions for People'. [2002] (325)(7366) *British Medical Journal* 711.

[61] L. Southgate & D. Dauphinee, 'Maintaining Standards in British and Canadian Medicine : The Developing Role of the Regulatory Body'. [1998](316) *BMJ* ; 316:697-700.

(iii). It may be argued that an international complaint and redress structure may create a lot of controversies within the international legal framework but if we examine the international framework available for the enforcement of human right globally, this demand cannot be seen as unwarranted. Further, other areas like Labour Law, has recorded enormous thrive in piercing through the domestic constrain that national laws give to it and has attained an international/ national balance. This it was able to achieve because there is a strong presence of international law regime.
(iv). Disparity between developing and developed nations: decisions reached by a lot of Conventions and Charters of international health bodies and organisations project a situation of 'one cap fits all'. This 'one –cap-fits-all' syndrome often fails to take into cognisance the peculiarity of each nation. When standards are created, it entails a lot of financial commitment which a lot of developing countries lack. There is no adequate human capital and resource backup for the developing nations to promote the adherence with the standards created. creating a unified redress regulation, builds the platform for developed nations to assist and create adequate support for developing nations.
(v). Promotion of 'Unionism' and Professional ideals are the centre of most vision and not the right and safety of patient. Since a lot of them are self-regulatory international organisations, these organisations appear to be focused on self-preservation. They appear to focus on ideals, practice and structures that will protect, promote and enhance the perception, standard of practice and dexterousness of their profession. In fact, this can be likening to a sort of professional conspiracy. The aims of some of these standards appear to be fashion at monitoring and controlling entrants to the various professional bodies.
(vi). However, the whole picture is not of glooms and inadequacies there are several strong points and benefits which can be derived from the coming together and formations of these organisations. The first is that there is the unity of ideals and focus despite the difference in race colour, culture, there is a common focus. Creating ideal which members can use to promote professionalism in their country, these bodies are creating international ideals and focus and it has a way to protecting the human race.
(vii). The prevalence of medical tourism brings to bear the need for international bodies to put in place a regulatory mechanism which will adequately protect a patient of other nations who seeks health and healing in other climate and jurisdiction of which the municipal law may not give the adequate protection for him. A lot of practices may be disallowed in the source countries but allowed in the destination countries. In fact, some of these practices may in actual fact be unproven in the source countries but used as 'experimental' treatment in the destination countries, when harm occurs in, conflict of laws case will then arise. Though most of the clinics involve often put jurisdictional clauses and 'choice of law' clauses this may be disadvantageous to the claimant. There is a need to put in place an internationally acceptable structure that will regulate and provide redress system.
(viii). The nature and peculiarity of each country makes this present structure look haphazard and inefficient, because what each nation is contending with differs. Advance countries like America and UK, are faced with issues such as over-regulation that has created the practice of defensive medicine.[62] Unlike developing countries such as Nigeria who is faced with serious infrastructural issues and other developmental challenges which are traceable to under-regulation. Having an international framework therefore helps both the developing and the developed world. If the world is able to find a middle way, there will be a combined focus which will give acceptable standards to all. Example can be drawn from the football world, where there is the existence of FIFA, who regulates, create standards and gives the appropriate redress structure that should be followed by all sporting countries. Though each country is autonomous in its own premiership league and footballing structures, but there is a global centre which each can draw standards from.

6. Conclusion

Redress and sanction in medical negligence operates at the national level with different structures in place by different jurisdiction. However, with the fast pace of globalisation and other ancillary issues, there is the need for a unified international legal framework. A patient should find an adequate redress system both locally and internationally, this cannot be achieved by creating standards alone as already existing with international bodies. When standards are created, there is the need to further monitor and enforce those standards and ultimately dole out sanctions when they are contravened, and this is the essence of regulation; each nation should be able to draw from an effective international legal framework. Although, there exist several international organisations, bodies and Conventions on health and health care and these bodies are doing good job at creating standards, and ideals which they expect all the professional annexed to them to adhere to. However, these global bodies and organisations seem to have been inadequate in regulating the aspects of medical practice which create redress for

[62] P. A. Manner, 'Practicing Defensive Medicine—Not good for Patients or Physicians' [Jan/Feb. 2007] *American Academy of Orthopedic Surgeons AAOS; D. M.* Studdert., *M. M.* Mello & W. M. Sage, 'Defensive Medicine Among High-Risk Specialist Physicians in a volatile malpractice environment'. [2005] (293)(21), *JAMA* ; 2609-17.

medical negligence. They appear too general and unspecific in their approach; it caters for the professional reputation of its profession rather than the specific rights, wellbeing of the patient. Albeit, it has been argued that the end users of many of its visions, missions and policy statements are the patient, but the link-line seems too far, long and unreachable to the common and average man who wishes to pursue his civil rights in times of breach by a healthcare giver. There should be an international redress system which can cater for the situations where negligence occurs, especially when local remedies are exhausted and patient is unable to get a satisfactory justice. This can be worked out like the human right courts, and the international criminal courts structures. International medical bodies should move from persuasive regulations to sanction-able regulations. There should be an international harmonised body which can carry out the first recommendation above. There should be better collaborations between developed and developing countries in areas of human capital development, infrastructure and process re-engineering. There should also be a meeting or conference by world health bodies, wherein they will come together to fashion out a minimum universally acceptable mode of seeking redress by aggrieved patient adaptable to different countries. A lot of conventions exist on virtually all aspect of medical practice except means of redress and regulating medical negligence.