

**MEDICAL JURISPRUDENCE IN NIGERIA: COMPARING THE LEGAL FRAMEWORK ON MEDICAL NEGLIGENCE WITH THOSE OF SOME WESTERN JURISDICTIONS\***

**Abstract**

*Medical jurisprudence is the branch of the law that regulates the application of law to medicine or conversely, it is the application of medical science to legal problems. In Nigeria there is a dearth in official reports, adjudication and prosecution of cases involving medical negligence; although instances of same occurs increasingly and unabated. As a result of this, there is an anecdotal and mistaken notion that there are not many instances or cases of medical negligence and that it is a herculean task to effectively redress medical negligence in Nigeria. In contrast, the situation in Western jurisdictions explicates a glaring difference as cases of medical negligence and medical malpractice are recorded and publicly adjudicated upon. This paper seeks to debunk the above mentioned notion, undertake a comparative analysis of medical negligence in Nigeria with selected jurisdictions, while addressing the reasons for the dearth of medical jurisprudence in the Nigerian society.*

**Keywords:** Dearth of Medical Jurisprudence, Legal Framework, Medical Negligence, Nigeria, Western Jurisdictions

**1. Introduction**

According to American surgeon, Richard Selzer, ‘If people understood that doctors weren’t divine, perhaps the odour of malpractice might diminish’<sup>1</sup>. There are increasing reports in the media of avoidable deaths, loses and damages occurring as a result of medical negligence occurring in health care facilities in Nigeria. Nigeria has in existence a plethora of legal and regulatory mechanisms for the redress and remedial actions of cases or instances of medical negligence, in addition there are rules of professional conduct for medical practitioners to curb all forms of unethical conducts and avoid incidence of medical negligence. In addition, medical malpractice law makes it possible for patients to recover compensation from any harms that result from sub-standard treatment. Despite a plethora of medical negligence prohibition legislations, instances of medical negligence still continue unabated, having deleterious impacts on the victims, this situation may be attributed to the increasing failure of victims to seek redress for medical negligence suffered. This deficit could be attributed to a number of factors which include social, cultural, religious and pecuniary factors<sup>2</sup>. When medical practitioners are negligent, it is their patients that pay the price. This article seeks to analyse the various factors that contribute to the apathy in litigation of medical negligence in Nigeria, compare and contrast it with the situation in Western jurisdictions, and make appropriate recommendations.

**2. Meaning of medical negligence**

In medico-legal parlance, the term, ‘medical negligence’ has been defined as ‘the failure of a health care provider to exercise the ordinary care and skill a reasonably prudent and qualified person would exercise under the same or similar circumstances’<sup>3</sup>. It is the improper, unskilled, or negligent treatment of a patient by a physician, dentist, nurse, pharmacist or other health care professional<sup>4</sup>. It was stated in the leading English case of *Bolam v Friern Hospital Management Committee*<sup>5</sup>, that negligence in the case of a medical man means failure to act in accordance with the standards of reasonably competent medical men at the time, which failure caused the injury suffered by the patient. It is important to note that medical negligence is generally used in reference to all health care practitioners. In the Indian case of *Dr. Laxmam Balkrishna Joshi v Dr. Trimbarak Godbole & Anor*<sup>6</sup>, it was held that a doctor consulted by his patient owes that patient certain duties which include but are not restricted to a duty of care in deciding whether to undertake the case, a duty of care in deciding what treatment to give, and a duty of care in the administration of that treatment. A breach of any of the aforementioned duties may give a cause of action for negligence and the patient may on that basis, recover damages from his doctor. A person owes a duty of care to another person where the injurious consequences of their actions are reasonably foreseeable, there is

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<sup>1</sup> R Selzer, *Mortal Lessons: Notes on the Art of Surgery* (Simon and Schuster, 1976) 53

<sup>2</sup> U Abugu, *Practice and Principles of Medical Law and Ethics* (University of Abuja Press, 2018) 322

<sup>3</sup> Dada (n 14) 87

<sup>4</sup> The Free Dictionary by Farlex <(the free dictionary by farlex) legal-dictionary.thefreedictionary.com> accessed 26 July 2019

<sup>5</sup> [1957] 1 WLR 582.

<sup>6</sup> [1969] AIR SC 128

proximity in the relationship between the persons, and it is fair, just and reasonable to impose such a duty<sup>7</sup>. Therefore, while a doctor owes his patient a duty of care because of their doctor/patient relationship, the same doctor does not owe the whole world the same duty of care. The doctor may have moral obligations to the world-at-large, but that moral obligation is unlikely to metamorphose into a duty of care in a tort claim of negligence<sup>8</sup>. In considering whether or not there is a breach of that duty, the courts will consider whether the defendant's acts or omissions are such that a reasonable person, in the same circumstances, would do or not do the same and whether the consequences of their acts or omissions were reasonably foreseeable<sup>9</sup>.

### 3. The legal Framework on Medical Negligence in Nigeria

#### Medical and Dental Practitioners Act 2004<sup>10</sup>.

Section 1(1) MDPA 2004 establishes the Medical and Dental Council of Nigeria which is saddled with the function of determining the standards of knowledge and skill to be attained by persons seeking to become members of the medical or dental profession and reviewing those standards from time to time as circumstances may permit, other functions as enumerated in the Act include: securing the establishment and maintenance of registers of persons entitled to practice as members of the medical or dental profession and the publication from time to time of lists of those persons; the removal and preparation of a code of conduct which the Council considers desirable for the practice of the professions in Nigeria; supervising and controlling the practice of homeopathy and other forms of alternative medicine; making regulations for the operation of clinical laboratory practical's in the field of Pathology which includes Histopathology, Forensic Pathology, Autopsy and Cytology, Clinical Cytogenetics, Haematology, Medical Micro-biology and Medical Parasitology, Chemical Pathology, Clinical Chemistry, Immunology and Medical Virology, and performing other functions conferred on the Council by this Act. While the Act does not use the word, 'negligence' or give specific instructions as to its handling thereof, the Code of Conduct<sup>11</sup> as provided for in section 1(2)(c) of the MDPA 2004 addresses professional negligence, recurrent professional negligence and gross professional negligence in its Part B and even provides for malpractice in its Part C. Rule 28 of the Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria provides that medical practitioners and dental surgeons owe a duty of care to their patients in every professional relationship, it explicates that:

The particular skill which training and eventual recognition and registration bestow on a practitioner, is to be exercised in a manner expected of any practitioner or any other member of the professions of his experience and status. It is required that a practitioner upgrades his skill as best as possible in the light of advancing knowledge in the profession. To this end, regular participation in programmes of continuing medical education is a necessary condition for the practitioner to remain relevant in practice and to achieve renewal of his practising licence based on the guidelines that are released by the Council from time to time<sup>12</sup>.

This provision explicates the dynamic nature of the medical profession the requisite standard of care required of a medical professional and acceptable professional conduct which is subject to change in line with evolutionary changes in the medical profession. It is therefore the duty of any competent medical practitioner to keep themselves updated with best evolving medical practices in the medical community. A practitioner must see and attend to all patients on admission under his care, as frequently as their conditions demand. In an emergency, for instance at the scene of a road traffic accident, a doctor passing by is under no inherent duty to stop and render first aid to the victims; but if he decides to stop and render care, he is bound by the ethics to exercise a degree of reasonable care, that is, to do everything that a competent and reasonable registered practitioner would do in the circumstance<sup>13</sup>. The Code of Conduct recognizes that due to the hardship and lack of satisfactory equipment and infrastructures in Nigeria there are many circumstances that are outside the control of medicine and dentistry that will impede the full realization of the doctor's skill. However, the medical practitioner is still required to act within the best possible degree of reasonable care obtainable under the circumstances. Thus, a registered practitioner who fails to exercise the skill or act with the degree of care expected of his experience and status in the process

<sup>7</sup> Dada (n 14) 89.

<sup>8</sup> Kaine Agary, 'Medical Negligence' *Punch Newspapers* (24 June 2018) 16

<sup>9</sup> Denning, *The Discipline of Law* (Oxford, Oxford University Press, 2005) 242

<sup>10</sup> Medical and Dental Practitioners Act 2004 Cap M8 LFN (MDPA 2004)

<sup>11</sup> The last revision in January 1995 was titled 'Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria.

<sup>12</sup> Rule 28 Code of Medical Ethics in Nigeria, 2008 (Also Code of Conduct)

<sup>13</sup> ENU Uzodike, 'The Doctor and the Law – Professional Negligence in Medical Ethics' (Lagos University Press, 1982) 45

of attending to a patient is liable for professional negligence. Section 15 MDPA 2004 establishes the Medical and Dental Practitioners Disciplinary Tribunal which is charged with the duty of considering and determining any case referred to it by the Panel and any other case of which the Disciplinary Tribunal has cognizance. The Disciplinary Tribunal is comprised of the Chairman of the Council and ten other members appointed by the Council including at least two fully registered dental surgeons. The Panel here refers to the Medical and Dental Practitioners Investigation Panel established under section 15(3). The Panel's responsibility includes but is not restricted to;

1. Conducting preliminary investigations into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner or dental surgeon.
2. Compelling any person by subpoena to give evidence before it.
3. Upon satisfaction that it is necessary for the protection of members of the public, it may decide to make an order for interim suspension from the medical or dental profession in respect of the person whose case they have decided to refer for inquiry and for the case to be given accelerated hearing by the Disciplinary Tribunal within three months.

The members of the Panel are appointed by the Council and consist of fifteen members including no less than three dental surgeons. Rule 29 of the Code of Conduct provides for recurring professional negligence and states that where a medical practitioner appears before the Disciplinary Tribunal for the second time on a negligence charge and is found guilty, he will not be given the option of admonition (as would be given to a first offender) but will immediately be suspended from practice for a period of at least six months. A habitually negligent medical practitioner may have his or her name struck off the relevant register. Rule 30 of the Code of Conduct provides for gross professional negligence. Negligence is supposedly gross where the degree or the extent of the negligence is so severe that it results in permanent disability or death. Where a medical practitioner is liable, even if it is the first time, he is liable to 6 months' suspension or having his name struck off the medical or dental register, which ever applies. The MDPA 2004 also makes provisions for penalties for professional misconduct and stipulates the penalties for any medical practitioner found guilty of medical misconduct or negligence to include:

- a. Order the Registrar to strike the person's name off the relevant register.
- b. Suspend the person from practicing as a medical practitioner or dental surgeon for no more than 6 months.
- c. Admonish the person.

#### **National Health Act, 2014<sup>14</sup>**

Part III of the National Health Act provides for the rights and obligations of the users and health care personnel. It provides in section 20 that a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason. This provision is in the benefit of a plaintiff and may cause a medical practitioner who chooses to practice defensive medicine at the time a patient is in a critical condition to be liable for that patient's wellbeing. Subsection (2) stipulates a fine of a hundred thousand naira (N100, 000) or six months' imprisonment or both for anyone in contravention of this section. Section 23 provides for the health provider to give the user i.e. patient full information of the state of his condition and any necessary treatment that may be employed. The only exception to doing so are cases where it may be shown that to give the user full disclosure would be detrimental to the health of the particular individual. Section 26 imposes upon the doctor, or health care provider, the duty of confidentiality, stating that all information relating to a user's health status, treatment or stay in a health establishment must be confidential. However, subsection (2) allows the information to be disclosed where;

- a. The user consents to that disclosure in writing.
- b. A court order or any law requires that disclosure.
- c. In the case of a minor, with the request of the parent or guardian.
- d. In the case of a person who is otherwise unable to grant consent, upon the request of a guardian or representative.
- e. Non-disclosure presents a serious threat to public health.

#### **4. The Nigerian Situation**

Abugu carried out an empirical research work<sup>15</sup> aimed at discovering the impression of Nigerians on the care and treatment they received from their doctors, the degree of medical malpractice claims by patients in Nigeria and

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<sup>14</sup> National Health Act Cap 315, LFN 2014

<sup>15</sup> U Abugu, 'A Critical Appraisal of the Legal Regime for Medical Malpractice Claims in Nigeria' (Ph.D. Thesis, Faculty of Law, University of Abuja 2015) 414

the reasons identified for the low level of claims against doctors by patients. It was discovered that of all the patients that participated in the survey, 61.69% felt that Nigerian doctors were arrogant and careless about their patient's condition or plight<sup>16</sup>. About 33.3% of Nigerian patients also indicated that as a result of their doctors' treatment, they suffered injury beyond their initial complaints<sup>17</sup>. Ordinarily, the undeniable high prevalence of medical malpractice as indicated by the responses of patients in the survey ought to provoke a correlative high level of malpractice actions,<sup>18</sup> however the level of claims filed in Nigeria remain abysmally low. The survey explicated that, in spite of the fact that a large number of the patients were in consensus regarding the poor healthcare services, only 40% of the respondents in the survey indicated that they were aware of their rights to make claims against their doctors for negligence or recklessness<sup>19</sup>. Worse still, only a dismal 1.1% of respondents ever made claims against doctors<sup>20</sup>. This dearth could be attributed to a number of factors including:

### **Illiteracy/Ignorance**

Plato in his book, 'The Republic'<sup>21</sup> stated that 'Ignorance is the root and stem of all evil'. When a patient is unaware that he suffered an injury as a result of medical, he/she cannot seek redress of a wrong unknown to him. The most common cause of ignorance is illiteracy and illiteracy is the bane of the Nigeria society. As at 2018, of the estimated 170 million people living in Nigeria, 75 million did not have basic literacy skills. Additionally, there were 10.5 million out-of-school children in Nigeria, making it one of the countries with the highest number of out-of-school children in the world<sup>22</sup>. The high level of illiteracy and ignorance in Nigeria has direct impacts on the will and capacity of medical negligence victims to seek redress through the appropriate legal channels, even the Bible explicates 'My people perish for lack of knowledge'<sup>23</sup>.

### **Poverty**

In recent times, poverty has been the bane of the Nigerian society<sup>24</sup>. Studies have shown that the average Nigerian lives on less than \$2 a day<sup>25</sup>. This adversely impacts the number of suits that are filed in Court on issues of medical negligence. With a growing number of Nigerians battling with endemic poverty, the awareness of the existence of a right to sue a doctor for medical negligence becomes irrelevant, because poverty divest people of their capacity to seek redress for medical negligence or other wrongs. A person may be burning with the zeal to redress a wrong in Court but may be incapacitated by poverty because adjudication and legal processes requires money.

### **Religious Beliefs**

Nigeria is a very religious country, which predominantly practices Christian religion, Islam and African Traditional Religion. As at 2017, 46.3% of the Nigerian population was Christian, 46% were Muslim, about 7.3% practiced African Traditional Religion and 0.3% belonged to a sprinkling of other religions<sup>26</sup>. These religions influence their followers and undermine the ability and necessity to seek legal redress in negligence cases. For example, in Muslim tradition, burial is usually within 24 hours of death to protect the living from any sanitary issues<sup>27</sup>. While this may not ordinarily be a problem, a person who seeks to take up an action of medical malpractice in respect of a dead relation may be impeded from so doing as proper documentation may not have

<sup>16</sup> ibid 424

<sup>17</sup> ibid 427

<sup>18</sup> Collins Chijioke, *The Legal Effect of Medical Negligence in Nigeria: An Appraisal* (Abia State University Press, 2007) 15

<sup>19</sup> ibid 17

<sup>20</sup> B Patel, 'Medical Negligence and res ipsa loquitur in South Africa' [2008] *1 South African Journal of Bioethics and Law*, 57

<sup>21</sup> Plato, *The Republic* (New York: Basic Books 1968) 66

<sup>22</sup> Jennifer Vecchiarelli, 'Nigeria comes face to face with a HUGE literacy crisis' (8 February 2018)

<<https://proliteration.org/Blogs/Article/311/Nigeria-Comes-Face-to-Face-with-a-HUGE-Literacy-Crisis>> accessed 1 September 2019

<sup>23</sup> Hosea 4:6 English Standard Version, the Holy Bible.

<sup>24</sup> Yomi Kazeem, 'Nigeria has become the poverty capital of the world' *A Dim Outlook*, 25 June 2018.

<<https://qz.com/africa/1313380/nigerias-has-the-highest-rate-of-extreme-poverty-globally/>> accessed 1 September 2019

<sup>25</sup> Everest Amaefule, '152 million Nigerians live on less than \$2/day – AfDB' *The Punch* (Nigeria, 6 February 2018)

<<https://punchng.com.cdn.ampproject.org/v/s/punchng.com/152-million-nigerians-live-on-less-than-2day-afdb/amp/>> accessed 1 September 2019

<sup>26</sup> Brian Grim and others, *Yearbook of International Religious Demography* (Leiden: Brill, 2017)

<sup>27</sup> Muslim Funeral Traditions; 10 Things You Should Know <https://cremationinstitute.com/muslim-funeral-traditions/>> accessed 1 September 2019

been done on the body before it was buried, it goes without saying that it is haram<sup>28</sup> to dig up a dead body. In a similar vein, the Christian doctrine preaches the message of forgiveness<sup>29</sup> and any devout Christian would be apprehensive at the thought of instituting a suit against a doctor for negligence as that would not be in the spirit of that message.

### **Social and Cultural Practices**

Despite religious influences, Nigeria value system is predominantly influenced by culture and tradition in varying facets of communal life including marriages, funerals and other rites. Many of these traditional practices do not permit westernized practices like autopsies as it is traditionally believed that tampering with a dead body is a taboo that may disturb the spirit of the dead individual<sup>30</sup>. On a social level, one will realize that the approach of an average Nigerian towards a doctor is one of awe, respect and reverence and any attempt to undermine the efforts of health care workers in treating patients is generally frowned upon.

### **Dissatisfactory Judicial Process**

The slow pace of the judicial system in Nigeria discourages litigants or complainants from seeking redress in the Courts of law. Court cases have been known to drag for more than 10 years<sup>31</sup> and sometimes to the point where parties to the suit have died<sup>32</sup>. The uncertainty that trails when a court case will end is a veritable disincentive to making legal claims for medical malpractice in Nigeria<sup>33</sup>. In addition, the adjudicatory system practiced in Nigeria makes the entire Court process very unattractive and it is often utilized as a last resort.

## **5. The Situation in Western Jurisdictions**

The statistics of medical negligence claims in Nigeria are fairly different from what obtains in more advanced jurisdictions like the UK, USA, Canada and Australia. In developed countries, there is the widespread practice of defensive medicine among doctors because of the high levels of medical malpractice claims. Advanced Countries engage in medical practices designed to avert future possibilities of malpractice suits also known as defensive medicine<sup>34</sup>. Defensive medicine in simple words, is departing from the normal practice of medicine as a safeguard from litigation<sup>35</sup>. It occurs when a medical practitioner performs treatments or procedures to avoid exposure to litigation<sup>35</sup>. It may be practiced in two major ways which are regarded as positive and negative defensive medicine. The former is done when the doctor prescribes unnecessary diagnostic tests, invasive procedures, unnecessary treatments, needless and hospitalization therefore taking the desire to avoid negligence or recklessness to an unnecessary extreme, wasting the patient's money and time on avoidable tests<sup>36</sup>. While negative defensive medicine may involve rejecting to attend to high risk patients or patients whose treatment procedures have an uncertain success rate. The demerits of this form of negative defensive medicine are that it excludes patients who might have benefitted from these treatments from partaking in them<sup>37</sup>. Generally, defensive medicine arose as a result of doctors' desire to protect themselves from the scourge of litigation, which is an ever growing trend in many parts of the Western World. An examination of the situation in western countries will be discussed hereunder.

### **United States of America**

The number of medical malpractice lawsuits in the United States tends to vary, but the overall trend is that they are on the rise. The annual number of suits filed each year is about 85,000, with the actual number of medical

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<sup>28</sup> Haram is anything that is expressly forbidden by the Islamic tradition. It is the highest form of prohibition.

<sup>29</sup> 2 Corinthians 2:5-8, 10; Luke 17:4 New King James Version, The Holy Bible

<sup>30</sup> Stuart Banner, *The Death Penalty: An American History* (Harvard University Press 2002) 82

<sup>31</sup> Ade Adesomoju, 'Judiciary still in search of solution to delayed justice' *The Punch* (Nigeria, 4 October 2018)

<sup>32</sup> *Okonji v Njokanma* [1991] 7 NWLR pt. 202, 131

<sup>33</sup> Uwakwe Abugu, *Practice and Principles of Medical Law and Ethics*, 53

<sup>34</sup> William Shiel Jr, 'Medical Definition of Defensive Medicine' (Medicine Net, 21 December 2018) <<https://www.medicinenet.com/script/main/art.asp?articlekey=33262> > accessed 19 August 2019

<sup>35</sup> Sonal Sekhar and N Vyas, 'Defensive Medicine: A Bane to Healthcare' <<https://www.ncbi.nlm.gov/pmc/articles/PMC3728884/> > accessed 19 August 2019

<sup>36</sup> Molly Gamble, Top 10 Reasons Physicians Practice Defensive Medicine <<https://www.beckerhospitalreview.com/legal-regulatory-issues/>> accessed 20 August 2019

<sup>37</sup> Assing Hvidt, 'How is defensive medicine understood and explained in a primary care setting? A qualitative focus group study among Danish general practitioners' <<https://bmjopen.bmj.com/content/7/12/e019851> > accessed 20 August 2019

injuries estimated to be about one million a year<sup>38</sup>. According to an article from the Journal of the American Medical Association, as many as 225,000 people die each year from medical negligence with 12,000 of those deaths from unnecessary surgery, 7,000 deaths from medication errors in hospitals, 20,000 deaths from other errors in hospitals, 80,000 deaths from infections and 106,000 deaths from non-error adverse effects of medication<sup>39</sup>. This means that there are eight times more injured people who never file claims than those who do and only about half of these people end up receiving any type of compensation. General surgeons, obstetricians and gynaecologists are the most likely to be sued as a result of the high-risk level in their areas of specialty. In the US, over 63 percent of general surgeons and OB/GYNs had a claim filed against them<sup>40</sup>.

### Canada

In Canada, a study<sup>41</sup> carried out in 2004 by the Canadian Medical Association revealed findings of similar studies in the United States, Australia, the United Kingdom, Denmark and New Zealand. The Canadian study concluded that as many as 24,000 patients die each year due to adverse effects<sup>42</sup>. 87,500 patients admitted annually to Canadian acute care hospitals experience an adverse effect. 1 in 13 adults admitted into a Canadian hospital encounter an adverse event. 1 in 19 adults will potentially be given the wrong medication or wrong medication dosage. 37% of all recorded adverse events are 'highly preventable while 24% of preventable adverse events are related to medication error. The rate of errors may be even higher today, some evidence suggests, despite the millions of dollars spent on much-touted patient-safety efforts. Yet a tiny fraction of those cases is publicly acknowledged and usually only in the form of antiseptic statistics.<sup>43</sup> In the study, the Manitoba province released for a three-year period between 2013 and 2015, a cursory look at what calamities could and had befallen patients<sup>44</sup>. Among the 100 cases reported in a three-month space that ended on September 30, 2013, was that of a new mother who had a heart attack after staff inadvertently gave her a blood-pressure-increasing medication, instead of a nausea antidote following a caesarean section. Another patient, known to be at risk for blood clots, suffered a fatal cardiac arrest when staff neglected to provide preventive treatment after surgery. A woman needed a second operation after an X-ray revealed a screw from a broken clamp had been left inside her during a C-section, while another patient underwent unnecessary open-lung biopsy<sup>45</sup>. For the rest of the country, such cases occur in a vacuum, most not reported at all and virtually none described with any kind of narrative. As a matter of fact, legislation in most Canadian provinces bars information on adverse events from being released to malpractice plaintiffs<sup>46</sup>. The laws are designed – albeit with limited success – to encourage internal reporting of mistakes to either a hospital board or council of physicians as deemed appropriate. This would imply that the Canadian health care system is one still confined by an old-fashioned hierarchy, fear of legal action and a focus on punishment rather than learning from mistakes.

### Australia

Australia has a high rate of clinical error, with as many incidents serious enough to justify legal action by medical negligence lawyers. Even high-density population areas such as Perth, Sydney, Adelaide and Melbourne which historically would be expected to have exemplary care have suffered from an epidemic of bad practice<sup>47</sup>. By some

<sup>38</sup> Philadelphia Medical Malpractice Statistics <<https://www-galfandberger-com.cdn.ampproject.org> > accessed 20 August 2019

<sup>39</sup> *Journal of the American Medical Association Network*, Library of Congress LCN83827 <<https://jamanetwork.com/medicalstatistoc017/>> accessed 20 August 2019.

<sup>40</sup> José Guardado, 'Medical Liability Claim Frequencies among US Physicians', (AMA Policy Research Objectives, 2017) 4

<sup>41</sup> Ross Baker, 'The Canadian Adverse Events Study: The Incidence of Adverse Events in Hospital Patients in Canada' (25 May 2004) <<https://www.ncbi.nlm.gov/pmc/articles/PMC408508/?report=classic> > accessed 20 August 2019

<sup>42</sup> An adverse event is any unexpected medical occurrence in a patient or any clinical investigation subject that has been administered a pharmaceutical product and does not necessarily have a causal relationship with this treatment.

<sup>43</sup> Tom Blackwell, 'Inside Canada's secret world of medical error: There is a lot of lying, there's a lot of cover-up' (16 January 2015) <<https://nationalpost-com.cdn.ampproject.org/v/s/nationalpost.com/health/inside-canadas-secret-world-of-medical-errors-there-is-lot-of-lying-theres-a-lot-of-cover-up>> accessed 3 September 2019

<sup>44</sup> Medical Malpractice Specialists in Manitoba <<https://www.jdmd.com/medical-malpractice-expert-manitoba/>> accessed 3 September 2019

<sup>45</sup> Peter Zed and Richard Slavik, 'Adverse Events in Canadian Hospitals: The Tip of the Iceberg' (1 June 2004) <<http://www.cmaj.ca>> accessed 3 September 2019

<sup>46</sup> Joan Gilmour, 'Overview of Medical Malpractice Law in Canada' (1994) Volume 3, *Annals of Health Law*, 179

<sup>47</sup> Medical Negligence Lawyers – What Every Patient Victim Should Know <<https://www.medneg.com.au/truth.html> > accessed 10 September 2019

estimates, as many as 18,000 people die every year as a result of medical error, while 50,000 people suffer a permanent injury<sup>48</sup>. Australia has one of the highest incidents of negligent clinical care in the developed world and according to a Quality in Australian Health Care Study, 80,000 Australian patients per year are hospitalised due to medication errors<sup>49</sup>. The establishment of the Australian Commission on Safety and Quality in Health Care<sup>50</sup> and the subsequent formalising of national safety standards in 2011 went a long way to driving adoption of best practices across the country. However, Australia still records an alarming number of cases per year. A recent report from the Productivity Commission revealed there were 10 sentinel events<sup>51</sup> in public hospitals across Queensland in 2014-2015<sup>52</sup>. According to ABC News, Queensland reported 47 sentinel events between 2010 and 2015, including operations on the wrong body parts, medication dispensing errors and surgical instruments being left inside patients<sup>53</sup>.

### **United Kingdom**

There is an increasing rate of medical malpractice incidents and claims in the UK. An article published by the British Medical Journal<sup>54</sup> revealed that five percent of hospital deaths in a study of one thousand patients in the UK were considered preventable<sup>55</sup>. The actual figure statistics for the year 2011-2012 showed that wrong site surgery occurred on an average of once every five days,<sup>56</sup> while the rate of diagnostic errors in standardised patient is about 15 percent.<sup>57</sup> A third of the patients were reported to have been misdiagnosed, or to have had a family member or close friend misdiagnosed. Of all the paediatricians surveyed in the article, half admitted to making mistakes at least once or twice a month, while NHS England identified 45,476 serious errors within a period of six months<sup>58</sup>. Finally, in spite of the seemingly appalling high rate of malpractice incidents in the country, only one in seven medical malpractice claims are made after adverse medical events,<sup>59</sup> which implies that majority of medical negligence victims never get justice. Upon a casual examination of these facts, it would be easy to assume that the situation in the western world is similar to what obtains in Nigeria. However, this is not the case as there is a dearth of accurate record keeping in Nigeria. While no record is ever completely fool proof, it is explicit that the recording instruments in Western World are accurate. This is coupled with the fact that studies are carried out on a frequent basis and results collated and shared in order to get a much fuller grasp on whatever situation is being inquired into. In Nigeria, there is neither frequent nor accurate documentation. The last census carried out in 2012 estimated the country's population to be at about 166.2 million people. In 2019, we are even more roughly estimated to be at about 201.9 million people and this number has been arrived at from very old research on the birth and death rates of Nigeria. As a result of this, many of the figures on new studies will not have accurate statistics to represent the true situation in Nigeria. When Abugu reports that only 1.1% of Nigerians ever make a claim against doctors for negligence<sup>60</sup>, the true figure might be much less than this. Conversely, it is only when the issue of medical negligence is genuinely appreciated that apposite steps can be taken to redress the problem.

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<sup>48</sup> Emily Bourke, 'Medical mistakes: A silent epidemic in Australian hospitals' (10 June 2013)

<<https://www.abc.net.au/worldtoday/content/2013/s3778256.htm> > accessed 10 September 2019

<sup>49</sup> Australian Institute of Health and Welfare, 'Australia's medical indemnity claims 2012-13' (11 July 2014) <<https://www.aihw.gov.au/>> accessed 11 September 2019

<sup>50</sup> Established in 2006 by the Council of Australian Governments (COAG) to lead and coordinate national improvements in the safety and quality of health care.

<sup>51</sup> The term refers to instances where a hospital system or process deficiency results in death or serious harm to a patient.

<sup>52</sup> Australian Government Productivity Commission Update (July 2015) <<https://www.pc.gov.au/>> accessed 12 September 2019

<sup>53</sup> Ellie Sibson, 'Queensland skin cancer patient sues doctor for medical negligence' (28 October 2018) <<https://mobile.abc.net.au/news/201-10-28/skin-cancer-patient-sues-doctors-for-medical-negligence/1042724> > accessed 12 September 2019

<sup>54</sup> Institute for Healthcare Improvement <<https://www.npsf.org/> > accessed 12 September 2019

<sup>55</sup> Jeremy Hunt 'NHS errors mean eight patients die a day' *The Guardian* (UK, 21 June 2013)

<<https://www.theguardian.com/politics/2013/jun/21/jeremy-hunt-nhs-errors-patients>> accessed 4 June 2020

<sup>56</sup> Nine Shocking UK Medical Malpractice Statistics <<https://www.1stclaims.co.uk/blog/2014/meical-negligence-claims/nine-shocking-uk-medical-malpractice-statistics/> > accessed 12 September 2019

<sup>57</sup> A standardised patient is someone who has been trained to portray, in a consistent, standardized manner, a patient in a medical situation. They are used for studies and evaluations. They are also referred to as simulated or sample patients

<sup>58</sup> NHS Choices – The UK's biggest health website and online front door to the NHS <<https://www.nhs.uk/>> accessed 12 September 2019

<sup>59</sup> Ibid

<sup>60</sup> Uwakwe Abugu, *Practice and Principles of Medical Law and Ethics* (University of Abuja Press, 2018)

## 6. Conclusion and Recommendations

This article explicates that there is an increasing rise in incidence of medical negligence in Nigeria, however there is a dearth of reportage and adjudication of medical negligence incidents in Nigeria. This article critically examined the legal and regulatory framework addressing issues of medical negligence, the challenges militating against the effective documentation, reporting and adjudication of such cases and undertook an assessment of the prevalence of medical negligence in Western countries and the approach of patients in redressing medical negligence. This article explicates the requisite need for appropriate documentation of facts, increased staffing in health care institutions and revamping of the health care institutions in Nigeria. The following recommendations are apposite to effectively mitigate the rising spate of medical negligence in Nigeria: In order to prevent defensive medicine among medical practitioner, comprehensive enlightenment campaigns should be carried out periodically to appropriately enlighten medical health workers with the prevailing best medical practices and standards. Health care workers should be encouraged to constantly enlighten their patients on all their rights and the requisite remedies available whenever their rights are breached. The dearth of standard medical facilities and equipment is a pivotal cause of medical negligence incidents in Nigeria; it is therefore apposite that the health sector generally be revamped and the government should provide standard medical facilities in public hospitals and support the private health sector with incentives and loans to revamp their health institutions. Many health institutions suffer from inadequate staffing, putting undue pressure on medical health workers and making them highly susceptible to mistakes: it is therefore explicit that appropriate attention is given to the health sector in the National budget and the practice of adequate staffing be encouraged in the health sector at all times. The Nigerian Medical Association should be encouraged not to clamp down on any of its members who testifies for victims against a medical doctor. This is referred to as bottleneck syndrome among the medical profession which encourages the 'conspiracy of silence' among medical doctors in actions against their colleagues. Finally, in the United Kingdom and the United States of America, there are compulsory insurance policies, which every hospital is advised to subscribe to in the event of medical negligence so that the hospital may be indemnified in such a situation. The government of Nigeria should emulate this practice and make it compulsory for all health institutions to have comprehensive insurance policies<sup>61</sup>. The Nigerian government should do more in addressing the issue of poverty in the country, because poverty limits the choice of patients and patients tend to prefer cheaper and substandard treatments which they can afford instead of standard medical treatments which is beyond their financial capacities.

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<sup>61</sup> Ali, Y O, 'Damages for Medical Practice: Nigeria as a Case Study'

<[http://www.yusufali.net/articles/damages\\_for\\_medical\\_practice\\_nigeria\\_as\\_a\\_case\\_study.pdf](http://www.yusufali.net/articles/damages_for_medical_practice_nigeria_as_a_case_study.pdf)> assessed 15 October 2019