SOCIO-CULTURAL, ECONOMIC, RELIGIOUS AND LEGAL IMPEDIMENTS TO THE IMPLEMENTATION OF THE LAW RELATING TO MEDICAL NEGLIGENCE IN NIGERIA*

Abstract

The law governing professional negligence in Nigeria, the subset of which is medical negligence is largely common law, handed down by the English system that was inherited, dotted here and there by a few judicial decisions. Despite the prevalence of modern medicine in the country, the medico-legal sphere has remained largely elementary nearly sixty years post-independence. Incidences of medical malpractice by health practitioners are widespread and in some instances, mind-boggling. However, these incidences are usually left unresolved and victims of malpractice prefer to 'leave the matter in the hands of God' rather than ventilate their grievances in the courts or through other legally permissible means. This article seeks to examine the socio-cultural, economic, religious and legal underpinnings limiting the effective realisation of the law relating to medical negligence and development of the medical law jurisprudence in Nigeria.

Keywords: *Law of Medical Negligence in Nigeria, Impediments, Socio-cultural, Economic, Religious, Legal*

1. Introduction

In the study of patients' knowledge and perceived reactions to medical errors from 269 in-patients conducted in 2013 in the University of Calabar Teaching Hospital, Nigeria, *Ushie, Salami, Jegede and Oyetunde*[1] reported that 64.5% of the respondents expressed annoyance and disappointment with medical errors. This study validates the claim that there is an epidemic of medical negligence in Nigeria. However, there is a sharp contrast between the incidences of medical negligence and the judicial decisions available on the matter. The reasons for this can be attributed to a number of factors- socio-cultural, legal, economic and legal. In this article, the law of medical negligence would be discussed. This would be followed closely by the statutes and policy documents governing medical practice in Nigeria. The remedies open to victims of medical negligence would be discusses next. The economic, socio-cultural, religious and cultural impediments to effective realisation of the law relating to medical negligence in Nigeria would be examined. Finally, the article will conclude with recommendations and conclusions on a more effective realisation of the law relating to medical negligence in the country.

2. Law of Medical Negligence

Negligence was defined by the Supreme Court in the case of *Odinaka v. Moghalu*[2]as 'the omission...to do something which a reasonable man, under similar circumstances would do or, the doing of something which a reasonable and prudent man would not do.' In a more recent case, the term was defined as 'the failure to exercise the standard of care that a reasonable prudent person would have exercised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm'.[3] Medical negligence, on its part, is defined as 'Professional carelessness committed by a physician or any relating staff member that does not conform to the accepted standard of medical practice and causes injury or even death to the patient. Medical negligence is failure on the part of a medical professional to exercise diligence, care, skill, knowledge and caution in administering treatments'.[4] For a claim to be actionable in negligence, and by extension, medical negligence; three elements must be proved. First, that a duty of care was owed by the defendant to the plaintiff; secondly, that the defendant breached the duty of care and thirdly, that damage was done to the plaintiff resulting from the breach.

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[1]B. A. Ushie, K. K. Salami, A. S. Jegede & M. Oyetunde, *Patients' knowledge and Perceived Reactions to Medical Errors in a Tertiary Health Facility in Nigeria*, African Health Sciences 2013; 13(3): 820-828 http://dx.doi.org/10.4314/ahs.v13i3.43 (accessed on 23rd January, 2019)

[2] (1992) 4 NWLR [Pt. 233] 1 at 15

[3] *Diamond Bank Ltd v. Partnership Investment Co. Ltd.* (2010) 13 WRN 42

[4] C. Briggs, *A Medical Practitioner in Nigeria*, The Nigerian Journal of Health and Biomedical Sciences, (2003), 4(2) p.165

Duty of Care

A medical practitioner owes a duty of care to his patient and this duty is independent of any contractual obligation. The neighbour principle formulated in *Donoghue v. Stevenson*[5] made it clear that the patient is a legal neighbour of the doctor and that a duty of care is therefore owed[6]. The medical profession recognizes this solemn duty and it is therefore stated in The Declaration of Geneva[7] that the physician in the practice of his profession shall ensure that *'the health of my patient will be my first consideration*,' and in the International Code of Medical Ethics[8] that *'a physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her.'* The scope of a doctor's duty was held to be a single indivisible duty by Lord Diplock in *Sidaway v. Board of Governors of the Bethlehem Royal Hospital and the Maudsley Hospital.*[9] A medical practitioner's duty of care is owed to three categories of people: the patient,[10] third parties[11] and an embryo.[12]

Standard of Care

In the law of negligence, the general rule is that the standard of care is that of the reasonable man acting in similar circumstance. The reasonable man has been defined in England to mean 'the man on the Clapham Omnibus'[13] and in Nigeria to mean: '(1) the peasant housewife shopping for a meal in Sand-grouse market, Lagos; or (2) the ordinary worker in Kano City; or (3) the plain woman in okrika dress.'[14] In *Bolam v. Friern Hospital Management Committee*,[15] McNair J. explained the standard of care required of medical practitioners thus:

> …where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art.

Therefore, with regard to medical practitioners, the standard of care is not the standard of the ordinary reasonable man who enjoys no medical expertise but that of a medical practitioner possessing similar expertise. In the Nigerian case of *Unilorin Teaching Hospital v. Abegunde*,[16] the Court of Appeal, per *Ogbuinya, JCA*, held that a medical practitioner should be liable in negligence: 'when he falls short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure'. The standard of care in Nigeria where medical facilities, including diagnostic equipment, are lagging behind those of western countries, the standard of care can hardly be the same. A Nigerian court dealing with a medical negligence case must therefore take care not to follow foreign decisions blindly without due consideration of local circumstances.[17] However, this can hardly be the case especially with respect to the fact that the standard of care in the important sector of health is universal. In a case where the medical practitioner is confronted with having to work under substandard conditions, the hospital management should bear individual

[5] (1932) AC 562
[6] W. Scott, *The General Practitioner & The Law of Negligence* (London; Cavendish Publishing Limited, 1995) p. 10
[7] Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
[8] Adopted by the 3rd General Assembly of the World Medical Association, London, England, in October, 1949
[9] (1985) A.C. 871 at 893
[10] *Barnett v. Chelsea and Kensington Hospital Management Committee* (1968) 1 All E.R. 1068
[11] *Bradshaw v. Daniel* (1994) Med L Rev 237
[12] *Burton v. Islington Health Authority* (1993) 4 Med LR 8; *De Martell v. Merton and Sutton Health Authority* (1993) 4 Med LR 8
[13] See *Bolam v. Friern Hospital Management Committee* (1957) 1 W.L.R. 582
[14] *Adigun v. AG Oyo State* (1987) 1 NWLR (Pt.53) 678 per Eso JSC (as he then was)
[15] (1957) 1 W.L.R. 582
[16] (2015) 2 NWLR (Pt. 1447) 421
[17] J. A. Dada, *Legal Aspects of Medical Practice in Nigeria*, 2nd Ed. (Calabar: University of Calabar Press, 2013), pp. 133-134

responsibility[18] for the negligence. This much was stated in the case of *Collins v. Hertfordshire County Council*,[19] it was held that the hospital authority were liable by reason of a negligent system in the provision of dangerous drugs. The standard of care applicable to the ordinary professional who is fully qualified is the same applicable to a trainee.[20]

Breach of Duty of Care

As stated earlier, there must be a breach of duty of care for an action in medical negligence to be founded. A breach of the duty of care may range from failure to take medical history,[21] failure to diagnose,[22] causing an injury to a patient while the patient is undergoing surgery,[23] failure to remove a foreign object inside a patient,[24] error in diagnosis[25] and failure to advise of material risks.[26] In *Chin Keow v. Government of Malaysia and Anor*,[27] the doctor administered penicillin to a patient and she died within an hour. He failed to inquire into the plaintiff's medical history although he had knowledge of the possibility of a patient developing hypersensitivity to penicillin. It was held that he failed in his duty and was accordingly liable in negligence.

Damage

The breach of the duty of care must have resulted in injury to the defendant before there is an action in negligence. There are two aspects of this: Causation and Remoteness of Damage.

Causation

Causation deals with the rules that determine whether the breach of duty of the defendant was, in fact, the cause of the damage. In medical negligence, the commonly applied test is the 'but-for' test. This test states that the injury occasioned to the plaintiff would not have occurred but for the negligence of the defendant.[28] The 'but-for' test is exemplified by the case of *Barnett v. Chelsea and Kensington Hospital Management Committee*[29]. In this case, three night watchmen called into a hospital at the end of a shift, complaining that they had been vomiting after drinking tea. The nurse on duty consulted a doctor by telephone who said that the men should go home and consult their doctor in the morning. Later the same day the plaintiff's husband died of arsenic poisoning. The doctor owed the plaintiff's husband a duty of care. In failing to examine the plaintiff's husband, the doctor had breached his duty of care, but the hospital was held not to be liable as the breach had not caused the death. The plaintiff's husband would have died even if the doctor had examined him. The 'but-for' test has its limitations especially in medical negligence. In the Nigerian case of *A.N.T.S v. Moloye*[30], the court held as follows: 'Causation as a fault-finding or fault placing mechanism whether in criminal law or in the law of torts has an element of fluidity in practical application to a given situation as it lacks specific fixation. It does not therefore serve useful purpose to seek a precise test'.

Different considerations apply in the following instances:

i. where the negligence did no more than cause the plaintiff to lose opportunity of cure ('lost opportunity causation');
ii. where some unrelated factor could perfectly well have been responsible for the damage ('unrelated factor causation'); and
iii. where his negligence merely made a contribution to the damage ('material contribution causation')[31]

[18] This is opposed to vicarious liability.
[19] (1947) 1 K.B. 598
[20] This was the decision in *Wilsher v. Essex Area Health Authority* [1986] 3 All E.R 801
[21] *Chin Keow v. Government of Malaysia and Anor* [1967] 1 WLR 813
[22] *R v. Crydon Health Authority*[1988] Lloyd's Rep Med 44
[23] *Paton & Another v. Parker*[1941] 65 CLR 187
[24] *Mahon v. Osborne* [1939] KB 14
[25] *Wood v. Queensland Medical Laboratories Unreported*, Supreme Court of Queensland, 16 December 1994 Reported in J. Devereux, *Medical Law: Text, Cases and Materials,* (New South Wales; Cavendish Publishing Limited, 1997) p. 131
[26] *Rogers v. Whitaker* (1992) 175 CLR 479
[27] [1967] 1 WLR 813
[28] See Lord Denning M.R. in *Cork v. Kirby MacLean Ltd* (1952) 2 All E.R 402
[29] (1968) 1 All E.R. 1068
[30] (1993) 6 NWLR (Pt. 278) 233
[31] See W. Scott, *The General Practitioner & The Law of Negligence* (London; Cavendish Publishing Limited, 1995) p. 43

In the first instance, the plaintiff usually alleges that had the diagnosis been made earlier, the condition would have been treated in time and he might have made a complete recovery. In this case, the rule is that unless the chances of recovery with good treatment exceeded 50%, the case must fail on causation.[32] In the case of 'unrelated factor causation', the negligence is alleged to not only result from the illness for which the defendant was treated but from other unrelated factors. In resolving the issue of causation, the court held in *Wilsher v. Essex Area Health Authority*[33] that a proper decision on causation could only be taken when a thorough comparison was made between the negligent cause and other possible causes that were not related to the negligence. In addition, it must be proved that the act alleged to be negligent is more than 50% likely to cause the damage. Finally, with regard to 'material contribution causation', the issue is usually whether the act or omission made a material contribution to the damage and the plaintiff need only prove on a balance of probabilities that the defendant's negligence materially contributed to the damage to recover the whole of his loss.[34]

Res Ipsa Loquitur

Where the plaintiff cannot explain how the accident occurred, he may rely on the principle of *res ipsa loquitur*. The defendant must then rebut the inference of negligence. A good illustration of this principle is the English case of *Cassidy v. Ministry of Health.*[35] Here, the plaintiff was suffering from *Dupuytren's contracture* and two of his fingers were operated upon. After the operation he found that the two fingers operated on were stiff and the stiffness had also passed to his other two good fingers. In the Court of Appeal, Denning LJ held that *res ipsa* applied because the operation was highly indicative of negligence. The *res ipsa loquitur* doctrine is, however, not applied automatically.[36] In addition, where the defendant has rebutted the inference of negligence, the onus lies on the plaintiff to show that negligence in fact occurred.

Remoteness of Damage

Remoteness of damage deals with whether a person should be held negligent for all injuries or damage done to a person by his negligent act, even if he could not have anticipated that those injuries would occur. The concept of remoteness of damage is one way in which the law sets limits to the extent of a person's liability for the consequences of his negligence, and the basic rule is that a defendant will be liable only for those consequences of his negligent act which are too remote in law, though such act may be said, on an application of the 'but-for' test, to have caused the damage complained of[37]. No defendant is responsible *ad infinitum* for all the consequences of his wrongful conduct, however remote in time and however indirect the process of causation, for otherwise human activity would be unreasonably hampered.[38] With regard to medical negligence, the same rules are applicable including the rule that the defendant must take his victim as he finds him or the 'eggshell skull' principle.[39] However, injury to a patient, as a consequence of the doctor's breach of duty, will rarely, if ever, be treated as unforeseeable.[40] In *Hepworth v. Kerr,*[41] a doctor was held liable for using an anaesthetic experiment on a patient, which resulted in a spinal stroke. The risk of inducing a spinal stroke was in fact not known about, but the risk of a cerebral stroke (thus making the procedure's use negligent) was.

3. Statutes and Policy Documents Relating to Medical Practice in Nigeria

[32] *Hotson v. East Berkshire Health Authority* [1987] AC 750
[33] [1988] A.C. 1074
[34] *Bonnington Castings Ltd v. Wardlaw* [1956] AC 613
[35] [1951] 2 KB 343
[36] *Ojo v. Gharoro* [2006] 10 NWLR (pt 987) 173
[37] Kodilinye & Aluko, *The Nigerian Law of Torts,* (Ibadan; Spectrum Law Publishing, 2nd ed. 1999), pp. 55-56
[38] Winfield and Jolowicz on Tort by W.V.H Rogers, (London; Sweet and Maxwell, 17th ed., 2006) p.291
[39] *Overseas Tankship (U.K.) Ltd v. Morts Dock & Engineering Co. Ltd The Wagon Mound (No. 1)*(1961) A.C. 388
[40] Marc Stauch and Kay Wheat with John Tingle, *Sourcebook on Medical Law,* (London; Cavendish Publishing Limited, 1999) p. 325
[41] [1995] 6 Med LR 139

Medical practice in Nigeria, like every other important aspect of our national life, is heavily regulated. The regulatory framework includes the Medical and Dental Practitioners Act,[42] National Health Act 2014, the Code of Ethics and the Patients' Bill of Right (PBoR).

Medical and Dental Practitioners Act

The Medical and Dental Practitioners Act (hereinafter called 'MDPA') came into force on the 28th day of June, 1988. The MDPA is the principal statute regulating the practice of medical practitioners and dental surgeons in Nigeria. The Act is divided into four parts. The first part (Sections 1-7) deals with the Establishment of the Medical and Dental Council of Nigeria. The second part (sections 8-14) contains provisions on the registration of medical practitioners and of dental surgeons. The third part (sections 15 and 16) deals with professional discipline of medical practitioners and dental surgeons including penalties for professional misconduct and the establishment of the Medical and Dental Practitioners Disciplinary Tribunal and Investigation Panel. The Act concludes with offences and penalties and other miscellaneous and supplementary provisions including regulations, rules, orders and interpretation in sections 17 to 22.

National Health Act 2014

The National Health Act was passed into law on the 31st of October 2014. The Act provides the framework for the regulation, development and management of a national health system and set standards for rendering health services in the federation. Notably, the Act makes provisions establishing the Basic Healthcare Provision Fund. Several bodies established under the Act include the National Council on Health,[43] the National Health Research Committee[44] and the National Health Ethics Committee.[45] Worthy of note is Part III of the Act which provides for certain rights and obligations of users and healthcare personnel. These rights and obligations range from the right of a patient to emergency treatment in every situation,[46] indemnity of a health care officer or employee for any costs incurred in any civil or criminal proceeding where he is held not liable for negligence or acquitted, as the case may be.[47] Part III also imposes a duty on health care providers to disclose all relevant information pertaining to the health of the patient.[48] A patient also has a right to confidentiality of all information disseminated to the health care provider.[49]

Code of Medical Ethics

The Code of Medical Ethics was issued by the Medical and Dental Council of Nigeria[50] on the 1st of January 2004. The Code covers all aspects relating to medical practice in Nigeria from the Physician's Oath, professional Conduct, and malpractice, relationship with colleagues and patients to sanctions for professional misconduct. The code also forbids abortion and euthanasia.

Patients' Bill of Rights

The Patients' Bill of Rights (PBoR) was launched on the 31st of July, 2018 by the Vice-President of the Federal Republic of Nigeria, Professor Yemi Osinbajo (SAN). The PBoR sets out the rights which should be enjoyed by patients. And as there cannot be a right without a corresponding duty/obligation, the obligations flowing from health practitioners are also set out. The rights provided for include patients' right to information about diagnosis, treatment, prognosis and other possible outcomes; right to access to records including information about scope of services, identity, skills and credentials of healthcare practitioners and providers; right to full disclosure of cost or estimation of recommended treatment plan services; right to privacy and confidentiality of his information and medical records; right to clean, safe and secure health environment and so on. In addition to the rules established by the courts set out in the previous section, it is submitted that non-compliance with mandatory provisions in these statutes and policy documents would ground an action in negligence.

[42] Cap M8 LFN 2004
[43] National Health Act 2014, Section 4
[44] National Health Act 2014, Section 31
[45] National Health Act 2014, Section 33
[46] National Health Act 2014, Section 20
[47] National Health Act 2014, Section 22
[48] National Health Act 2014, Section 23
[49] National Health Act 2014, Section 26
[50] Established by Section 1 of the Medical and Dental Practitioners Act Cap M8 LFN 2004

4. Remedies Available in the Event of Medical Negligence in Nigeria

It is trite that where there is a law, there must be a remedy.[51] A number of remedies are available to victims of medical negligence. These remedies include:

Civil Action for Damages

This is the usual course of action for victims of medical negligence. Where the court finds that all the elements of medical negligence are present, it would go ahead to award damages to the plaintiff. In *Igbokwe v. UCH*,[52] the deceased, after having being diagnosed with psychosis was left unmonitored and died from falling from the fourth floor of the hospital. Damages were awarded against the University College Hospital Management Board for medical negligence resulting in the death of the deceased. Liability for medical negligence could either be individual[53] or vicarious.[54]

Criminal Prosecution

Criminal prosecution of a medical practitioner for acts or omission resulting in negligence may fall under two heads: criminal negligence and manslaughter.

Criminal Negligence

Although, medical negligence is largely a tort, there are provisions in the Criminal Code which suggest that medical practitioners could be prosecuted for medical negligence.

Section 303 of the Criminal Code states that:

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

Section 305 also states that:

> When a person undertakes to do any act the omission to do which is or may be dangerous to human life or health, it is his duty to do that act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty.

In the two provisions above, a medical practitioner would be held liable for any consequences which result from his act or omission. Section 343(1) of the Code provides that:

> Any person who in a manner so rash or negligent as to endanger human life or to be likely to cause harm to any other person-
> (e) gives medical or surgical treatment to any person whom he has undertaken to treat; or
> (f) dispenses, supplies, sells, administers, or gives away, any medicine, or poisonous or dangerous matter is guilty of a misdemeanour, and is liable to imprisonment for one year.

Section 343(1) stipulates a penalty of one year imprisonment for medical negligence unlike the other two sections set out above which merely state the existence of the duty under the penal statute without providing punishment for the breach of that duty. For a medical practitioner to be criminally liable in negligence, the act or omission complained of must be 'gross negligence'.[55] In *R v. Akerele*,[56] the accused, a medical practitioner, administered injection known

[51] This is expressed in the Latin maxim *ubi jus ibi remedium*
[52] 1961 WRNLR 163
[53] See *Olowu v. Nigerian Navy* (2011) LPELR-SC.182/2007
[54] *Igbokwe v. UCH*, supra
[55] *Kim v. The State* (1992) 4 NWLR (pt. 233) 17
[56] (1942) 8 W.A.C.A 5

as sobita to some children to cure yaws. He administered overdose to the children and some of them died. The court held that his action did not amount to gross negligence. Unlike civil action, in a criminal prosecution for medical negligence the act or omission complained of must be rash, reckless and in disregard for the safety of the person treated.[57] This may be one of the reasons why litigants prefer to pursue civil actions because it will be very difficult to succeed under criminal negligence.[58]

Manslaughter

Section 317 of the Criminal Code defines manslaughter in this manner: 'A person who unlawfully kills another in such circumstances as not to constitute murder is guilty of manslaughter'. Murder is defined in Section 316 of the Criminal Code and a common thread running through the various acts constituting murder is intention to cause the death or grievous bodily harm of another. Therefore, manslaughter can be defined as the causing of the death of another without the corresponding intent to kill or cause grievous bodily harm. Death resulting from a negligent act of a medical practitioner would fall into the category of involuntary manslaughter (as opposed to voluntary manslaughter) because there is no intention to kill by a medical practitioner who may have caused death as a result of his negligence.[59]

Disciplinary Measure by the Medical and Dental Practitioners Disciplinary Tribunal

The Medical and Dental Practitioners Disciplinary Tribunal is the arm of the Medical and Dental Council responsible for the discipline of medical and dental practitioners.[60] The Tribunal has the statutory duty of considering and determining any case referred to it by the Medical and Dental Practitioners Investigation Panel.[61] Thus, a person aggrieved with the manner in which he was treated by a medical or dental practitioner would report such person to the Investigation Panel.[62] The Investigation Panel would then conduct preliminary investigations into the alleged irregularities and misconduct complained of and upon satisfaction that there is a case to answer, would refer it to the Disciplinary Tribunal for appropriate action. The Investigative Panel may also make an order for interim suspension of the medical or dental practitioner in question.[63] The sanctions that may be imposed by the Disciplinary Tribunal include ordering the Registrar to strike the person's name off the relevant register or registers; suspending the person from practice by ordering him not to engage in practice as medical practitioner or dental surgeon (for a period not exceeding six months as may be specified in the direction); or admonishing that person.[64] The National Health Act in Section 30 provides as follows:

> (1) Any person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated.
> (2) The Minister, Commissioner or any other appropriate authority shall establish a procedure for the laying of complaints within the areas of the national health system for which the Federal or State Ministry is responsible.

There is no laid down procedure by the Minister or Commissioners of Health and it is submitted that the procedure will be as stipulated under the Medical and Dental Practitioners Act. That is, an aggrieved person would make a complaint to the Medical and Dental Practitioners Investigation Panel which would then conduct preliminary investigations and refer the case to the Medical and Dental Practitioners Disciplinary Tribunal. The Patients' Bill of Rights (PBoR), on its part, also provides for a complaint procedure. It states that the patients' rights include the right to:

> 1) Complain in accordance with redress mechanism of the facility.

[57] J. O. Odia & A. R. George, *Law and Ethics of Medical Practice in Nigeria* (Port Harcourt; University of Port Harcourt Press, 2nd ed. 2015), p. 112
[58] Odia & George. *supra*
[59] Odia & George, *supra*
[60] Medical and Dental Practitioners Act, Section 15(1)
[61] Ibid
[62] Medical and Dental Practitioners Act, Section 15(2)
[63] Medical and Dental Practitioners Act, Section 15(2)(c)
[64] Medical and Dental Practitioners Act, Section 16(2)

2) Provide sufficient details of dissatisfaction.
3) If dissatisfied with outcome, report to the appropriate regulatory authority e.g. Medical and Dental Council of Nigeria (MDCN) and subsequently to Consumer Protection Council (CPC), if not satisfied with the additional interventions.

Thus, any party who alleges an infringement of any of the rights stated in the PBoR could make a complaint in accordance with the mechanism provided by the facility where the alleged infringement occurred and if dissatisfied, report to the Medical and Dental Council of Nigeria, specifically the Medical and Dental Practitioners Investigative Panel and if not satisfied, to the Consumer Protection Council (CPC). It is doubtful what role the CPC would play in this issue as it has no supervisory jurisdiction over medical practitioners. Under the statute establishing the Consumer Protection Council, the only function that relates to complaints is Section 2(a) and it provides that: 'The functions of the Council shall be to provide speedy redress to consumers' complaints through negotiation, mediation and conciliations.'

Therefore, the CPC may only try to broker the peace between aggrieved patients and/or their relatives through the Alternative Dispute Resolution processes of negotiation, mediation and conciliation and no further.

5. An Examination of the Socio-Cultural, Religious and Legal Impact on Medical Negligence in Nigeria

As can be gleaned from the foregoing, the law of medical negligence in Nigeria is still shaped by foreign judicial precedents which have but persuasive authority in Nigerian courts. Nigerian cases are few and far between. The reported cases on medical negligence include *Igbokwe v. University College Hospital Management Board*,[65] *Unilorin Teaching Hospital v. Akilo*,[66] *Ojo v. Gharoro*,[67] *Olowu v. Nigerian Navy*,[68] *Abi v. CBN*,[69] *Unilorin Teaching Hospital v. Abegunde*,[70] *Kaja v. Oke*,[71] *Daru & ors v. Umar & ors*,[72] *MDPDT v. Okonkwo*,[73] *Esabunor v. Faweya*,[74] *and Plateau State Health Services Management Board & Anor. v. Goshwe*.[75] Of these cases, the doctrine of *res ipsa loquitur* was considered in four cases.[76] In another, it was whether a Court-Martial had jurisdiction to try medical negligence.[77] In two others, the issues related to consent of a patient to treatment vis-à-vis fundamental human right of freedom of religion.[78] In yet another, the issue before the Supreme Court was the question of damages for medical negligence.[79] In another two, the matter ended on preliminary objection to jurisdiction.[80]

Despite the myriads of remedies available to victims of medical negligence in Nigeria, there is an acute paucity of recorded judicial decisions on the matter. Therefore, the law remains largely theoretical and foreign with little or no local content as it affects the Nigerian society and its citizens who, more often than not, have been victims of medical negligence in the hands of those to whom they trusted their health and physical wellbeing. The reasons for the unwillingness of Nigerians to litigate claims arising from medical negligence, and consequent underdevelopment of the medical negligence jurisprudence, stem from certain social, cultural, religious and even economic biases. These

[65] 1961 WRNLR 163
[66] [2001] 4 NWLR (pt 703) p.246
[67] (2006) 10 NWLR [Pt. 987] 173
[68] (2011) LPELR-SC.182/2007
[69] (2011) LPELR-CA/A/262/2007, (2012) 3 NWLR (Pt. 1286)
[70] (2013) LPELR-21375(CA);
[71] (2013) LPELR-19908(SC)
[72] (2013) LPELR-21905(CA)
[73] (2001) 6 NWLR (Pt.711) 206
[74] (2008) 12 NWLR (Pt. 1102) 794
[75] (2012) LPELR-9830(S.C.)
[76] *Igbokwe v. University College Hospital Management Board,* supra; *Ojo v. Gharoro*, supra; *Abi v. CBN*, supra; *Plateau State Health Services Management Board & Anor. v. Goshwe* supra
[77] *Olowu v. Nigerian Navy*, supra
[78] *Esabunor v. Faweya*, supra; *MDPDT v. Okonkwo*, supra
[79] *Kaja v. Oke*, supra
[80] *Daru & ors v. Umar & ors, supra; University of Ilorin Teaching Hospital v. Akilo,* supra

biases would now be discussed. First is the socio-cultural view that doctors are next to God. In other words, doctors are very important in the society and subjecting their actions to litigation may limit their efficiency. Undoubtedly, the courts also recognise this as one of two policy considerations to be borne in mind when adjudicating medical negligence cases- the other being ensuring that individuals who have suffered harm as a result of the negligence of a medical practitioner are adequately compensated.Second is the religious sentiment of the vast majority of Nigerians. Most religions emphasise forgiveness. Therefore, victims of medical negligence and their relatives would prefer to leave the matter to God rather than ventilate their grievances in a court of law. This point is reiterated by *Ushie, Salami, Jegede and Oyetunde*[81] whose report indicate that of 89.2% of respondents would like their caregivers to voluntarily report the mistake to them, 64.7% would forgive them. Another major impediment is the harsh economic realities of the people. Recently, Nigeria was ranked as the country with the highest number of poor people in the world, with 87 million people living in extreme poverty.[82] With people struggling to feed, it is almost impossible for them to litigate negligence claims in court bearing in mind the high cost of litigation. Another aspect of financial constraint is the financial difficulty that arises from error.[83] Due to the unpopularity of health insurance in Nigeria coupled with government under-financing of the health sector, a major illness afflicting a member of a family would lead to the dwindling of the economic fortunes of that family. The resultant effect is that many claims would go without redress.

Furthermore, there are hurdles within the legal system itself. First, is the delay in cases getting decided which results in an apathy towards litigation and the court system in general. In *Plateau State Health Services Management Board & Anor v. Goshwe*[84], an injury that occurred sometime in August 1990 was not settled until 2012 when the Supreme Court gave final judgment in the matter. That is a whopping 12 years from the date of filing the suit at the High Court. A second legal hurdle that arises is in relation to Medical practitioners who are public servants. By virtue of section 2(a) of the Public Officers' Protection Act,[85] where a person is aggrieved by an act, neglect or default of a medical practitioner who is a public officer, he must institute his claim within three months of the occurrence of such act, default or neglect, otherwise his claim would be statute-barred. The only exceptions are where it is proved that there is a continuance of damage or injury,[86] or that the medical practitioner acted outside the scope of his official duties.[87]

6. Conclusion and Recommendations

The myriads of challenges militating against the effective realisation of the law relating to medical negligence in Nigeria have been enumerated in the forgoing section. The financial and economic challenges may be addressed by holistic fiscal and economic reforms by the government on the broader scale and also the sensitisation of citizens on the need for health insurance covers. On the flip side, the current legal framework discourages claimants from accessing its services as explained above. A viable alternative to litigation as a means of redress is through the employment of Alternative Dispute Resolution (ADR) mechanisms. Mediation and Arbitration in particular are mechanisms that are currently in use in developed countries. Furthermore, the authors lend their voices to the campaign for the repeal of the Public Officers Protection Act. It is trite that the vast majority of Nigerians seek medical help from public health institutions all over the country. Private health institutions do not enjoy as much patronage as their public counterparts. Therefore, the barring of claims not instituted after the statutory period would work untold hardship on aggrieved claimants. In this article, an attempt has been made at examining the jurisprudence of medical negligence in Nigeria including the statutes and policy documents which have an influence on medical negligence in Nigeria. Furthermore, the impediments to effective realisation of the law relating to medical negligence have been explained and recommendations proffered.

[81] Ibid
[82] https://www.brookings.edu/blog/future-development/2018/06/19/the-start-of-a-new-poverty-narrative/ accessed on 5th February, 2018
[83] Ushie, Salami, Jegede & Oyetunde, Op. cit.
[84] (2012) LPELR-9830(S.C.)
[85] Cap P41 LFN 2004
[86] *Attorney-General of Rivers State v. Attorney-General of Bayelsa State & Anor*. (2013) 3 NWLR (Pt. 1340) 123
[87] *Nwankwere v. Adewunmi* (1967) NMLR 45