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Appraisal of the Liability of Health Care Practitioners and Facilities for Medical Negligence in Nigeria: A Case Study of Plateau State, Nigeria.

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ABSTRACT: Healthcare system in Nigeria has recorded unimaginable and unsatisfactory performance in quality health care delivery. There is need to promote the awareness of medical negligence due to the fact that at some point in life, one has fallen victim of medical negligence, but as a result of ignorance it was swept under the carpet. Medical negligence is not synonymous with doctors only but extends to nurses, laboratory scientists, laboratory technicians and other paramedics and the health care institutions in general. This research therefore, examined the level of awareness of the legal remedies for medical negligence against healthcare practitioners and facilities in Plateau State, Nigeria; the extent to which the residents of Plateau State are aware and willing to prosecute legal actions for medical negligence where committed by health care practitioners and also investigate the factors which hinder persons from enforcing their rights through legal means. The survey research method was employed. A sample size of 384 respondents was drawn from the population of study using the Wimmer and Dominick on-line sample size calculator using a confidence level of 95% and precision level of 5%. Findings showed that most of the sampled respondents are not aware of the remedies available to patients in the event of medical negligence caused by healthcare practitioners and facilities. The study therefore recommended among others that, the government and other agencies in the private sector should be proactive in educating the populace on their rights to quality health care services and the availability of legal redress for medical negligence.

Keywords: Liability, Health Care Practitioners, Facilities, Medical Negligence

Introduction

Every human by nature is entitled to maintain some form of trust in the health institution where medical services are rendered. The health institution is required to keep all that is necessary to render adequate treatment to her clients both in terms of personnel and equipment especially in developing countries where health care practitioners lack basic functional information (Pakenham-Walsh & Bukachi, 2009). Medical negligence arises when a healthcare practitioner or provider fails to provide adequate medical care or carries out substandard treatment that causes harm, injury or loss of life to

the patient. To establish medical negligence, it must be proved that a legal duty of care exists, that there is a breach of that duty of care and that damage has been suffered as a result of the breach (Melami, 2013). Negligence of health institutions can be vicarious while that of the personnel could be personal in some cases. This is aimed at ensuring that medical practitioners align with international best practices and guaranteeing the patient's enjoyment of his privacy in his relationship with medical practitioner and the health institutions. The Central Bank of Nigeria's Balance of Payments report in 2022 revealed that Nigerians paid $11.01bn for healthcare-related services in foreign countries (Popoola & Orjiude, 2022). All three tiers of government- Federal, State and Local share responsibilities for providing health services and programmes in Nigeria. The Federal government is responsible for coordinating affairs in Federal Medical Centres and University Teaching Hospitals. The State government is responsible for running general hospitals while the Local government is responsible for dispensaries. In late 2014, the Federal Government signed the National Health Act and approved the establishment of state-supported health insurance scheme by the National Council on health. More specifically, the Federal Ministry of Health (FMOH) is responsible for policy and technical support to the overall health system, inter-national relations on health matters, the national health management information system and the provision of health services through the tertiary and teaching hospitals and national laboratories. The state ministries of health (SMOH) are responsible for secondary hospitals and for the regulation and technical support for primary health care services. Primary health care is the responsibility of the local government where health services are organized through the ward.

The Hospital Services Division has the following units under it: Teaching Hospitals, Federal Medical Centres and Specialty Hospitals. The Units are saddled with the responsibility of supervision of the various Federal Tertiary Hospitals. The activities of the Federal Ministry of Health, parastatals, agencies, state ministries of health and all interested stakeholders are coordinated through the National Council on Health. Similarly, in each state, the state Council on Health is expected to bring together the state ministry of health and the local government health authorities.

Medical negligence is not particularly ascribed to medical doctors only. It extends to nurses, dentists, health care facilities and other health care providers. However, this study brings to light the culpability of Hospitals and health care centres. In the context of medical malpractice actions, hospitals.

can be held directly liable for their own negligence and can also be held 'vicariously' liable for the negligence of their employees. Vicarious liability means that a party is held responsible not for his own negligence, but rather for the negligence of another (Okpeh, 2021) Many serious claims for medical malpractice arise from procedures and treatment given to patients in hospitals. The hospital itself is generally liable for any action of its employees that are undertaken within the scope of their employment with the hospital. A hospital is responsible for the actions of its employees, be that a doctor, nurse or the person involved in the provision of healthcare services as long as that person is acting within the scope of his or her employment, providing health care services to patients for the hospital (Jackson & Powell, 2006).

Not all doctors working in a hospital facility are employees of the hospital. He or she may have privileges to use the hospital facilities to provide medical care and treatment for patients. These types of doctors often bill patients for services directly rather than through the hospital, but that may not always be the case. Some doctors are independent contractors rather than employees of the hospital and in such situations, the hospital may not be liable for negligence of those doctors. There are however a number of exceptions to that general rule and it is important to consult with a Lawyer for

a careful analysis on a case by case basis before concluding that the hospital is not liable for an injury that occurred in a hospital or medical facility setting. The main point that most consumers need to understand about hospital liability for the negligent actions of its employees providing medical treatment and assistance to the public is that, it would be best to consult with a lawyer to determine if the facility has any liability for an injury that may have happened on its facility. It might be difficult to access the kind of employment agreement or privileged contractual term that would evidence the nature of employment status of that individual for the purpose of properly assessing the liability of the hospital facility for any given injury situation. If an employee of a hospital causes harm or injury to a patient in the course of his employment, the hospital is liable. In other words, if the employee is negligent in carrying out his duties, the hospital is on the hook for any resulting injuries to the patient. It is also pertinent to state that not every mistake or unfortunate event that happens in a hospital rises to the level of negligence. Whether a doctor is a hospital employee depends on the nature of his or her relationship with the hospital. Though some doctors are hospital employees, some doctors are not. Non-employee doctors are independent - contractors which means that the hospital cannot be held liable for the doctor's medical malpractice, even if the malpractice happened in the hospital (Scott, 1998). In the case of (Collins v Herts County Council, 1947), Hilbery J. held that 'a hospital authority is liable for the act of a resident junior house surgeon, but not for those of a visiting surgeon'.

In (Cassidy v Ministry of Health 1951), the Court of Appeal held that the hospital authority was liable for all the medical staff who had treated the plaintiff during his operation and afterwards, accordingly, the plaintiff could rely upon the doctrine of res ipsa loquitur. A doctor is more likely to be an employee rather than an independent contractor, if the hospital controls the doctor's working hours and vacation time or the hospital sets the fees the doctor can charge. A hospital can be held primarily liable for an injury on other grounds. For example, a hospital is obliged to provide and maintain equipment necessary to provide proper surgical procedures to patients undergoing surgery. This equipment should be functioning in safe, good working order at all times and should be inspected to document that it is in a safe condition for patient use. Hospital personnel must have been adequately trained in the correct operation of the facility, medical equipment and all equipment malfunctions should be reported to the correct authority. If hospital personnel are aware that a piece of equipment is being improperly used by a doctor during a surgery, they are obliged to object and report the problem in order to prevent any patient injury from happening. A hospital is also required to have an adequate amount of operating rooms and enough staff to handle the number of planned procedures each day. A hospital would be liable for an injury that happened where it did not cancel a procedure that it knew it could not provide a proper operating room to conduct the procedure and a doctor was allowed to begin the procedure anyway causing patient injury as a result. However, it should be noted that mishaps may occur not because of negligence of individual doctors or nurses, but because of bad administration or an unsafe system of work. In (Collins v Herts County Council 1947), it was held that the hospital authorities were liable by reason of a negligent system in the provision of dangerous drugs. Broadly speaking, a person is liable for negligence of employees when acting in the course of their employment, but not for the negligence of independent contractors.

The modern theory of vicarious liability is thus predicated exclusively on consideration of social policy and not on fault based. In (C.I Ltd v Shatwell. 1965), a person who employs another to advance his own economic interest should be held responsible for any harm caused by the activities of such employees. This way, the innocent victim of the employee's tort would be able to sue a financially responsible defendant. There is an important qualification in the concept of vicarious liability which must be well noted. An employer is only vicariously liable for the tort of his servant

committed in the course of his employment, that is, while the servant was doing the job he was employed to do. Therefore, if the servant was on a frolic of his own, his employer will not be vicariously liable. According to (Winfield and Jolowicz 2006), a tort comes within the course of the servant's employment if:

(a) It is expressly or impliedly authorized by his master;
(b) It is an unauthorized manner of doing something authorized by his master or
(c) It is necessarily incidental to something which the servant is employed to do.

Statement of the Problem

It has been observed by many erudite scholars that the performance of the health care system in Nigeria is abysmally poor and below good standard. Health care services remain out of the reach of many people, especially the poor. In some other cases, patients are faced with sub-standard health care services due to negligence on the part of health care providers. (Enemo, 2012; Ogundare, 2019; Ogbah, 2022). Unfortunately, many people in Nigeria are oblivious of their legal rights and even when they are informed and aware of such rights, they are reluctant to approach the law courts for enforcement due to certain factors such as poverty, illiteracy, corruption and delay which characterise the Nigeria's legal system.(Tom, 2020; Dada, 2012; Orimobi, 2015; Enemo, 2012, Nlerum Okogbule, 2005). Consequent upon the foregoing, this study became imminent. It is our firm belief that the method of research survey adopted in this paper would provide reliable objective data for the subject-matter of the discourse more than a doctrinal research method.

Objectives of the study

The specific objectives of this study were to:

1. To ascertain whether citizens in Plateau State Nigeria are aware of legal remedies for liabilities arising from medical negligence committed by health care practitioners and facilities.
2. To examine the extent to which citizens in Plateau State Nigeria are willing to enforce their rights through legal means against health care practitioners and facilities for medical negligence.
3. To find out the factors that impede the enforcement of rights in medical negligence cases in Plateau State, Nigeria.

Literature Review

Health care is an important aspect of life which every person is eligible to have unhindered access to. An efficient health care delivery is a sure way to the eradication of diseases to a larger extent and improving the quality and standard of life. Unfortunately, some people across the world are unable to experience the humongous benefits derivable from health care system due to poverty, illiteracy, medical negligence and devastating impacts of war. In the health care sector, health care practitioners owe certain duties to their clients the breach of which, gives rise to a cause of action for medical negligence against the medical practitioner or facility in question. In Nigeria, there have been reports of medical negligence attributed to health care practitioners and facilities with a very minimal level of formal complaints or law suits due to certain factors (Resolution Law Firm, 2020). It was for this reason that Hon.Jude Ngaji, the member representing Yala/Ogaja Federal Constituency in the House of Representatives, on 5th April, 2022, strongly advocated the investigation of medical practitioners who caused or maimed any member of the public due to medical negligence. (Ogar, 2022).

(Enenmuo, 2012) defined medical negligence to mean the breach of a duty of care committed by a medical practitioner to a patient which gives rise to damage to the patient. According to the writer, medical negligence gives rise to both civil and criminal liability and that in cases of criminal liability, the degree of negligence required of a health care practitioner is that the negligence should be gross and not mere negligence.

(Malemi, 2013) in his book 'Law of Tort', discussed the elements of negligence and different forms of professional negligence. He pointed out that the duties which a medical practitioner owes his patient include the duty to warn the patient on the risk of treatment, duty to carry out proper diagnosis and the duty to administer proper treatment. Although the author seemed to have restricted his work to medical doctors and not all health care practitioners, yet he carried out a detailed exposition of medical negligence.

(Roger, 1994) explained that the determination of what constitutes reasonable care is based on the standard fixed by the court and not by the relevant profession even though the practice of the profession should also be considered. (Ibitoye, 2018), found that although negligence has deeply crept into the Nigerian health care system, citizens do not initiate legal actions against erring practitioners. Although the views expressed by the writers are in tandem with the authors' findings, it is intended that this study shall offer further and elaborate discussions on the subject.

Civil liability for medical negligence

Civil liability in the medical profession arises when the patient is not treated according to acceptable standard of care. The liability of medical healthcare providers is judged by an objective standard as a measure of professional conduct, although liability is generally fault-based. There is really no correlation between doctor's negligence and moral blameworthiness. We must admit that mistakes are part of human nature; some mistakes may be as a result of negligence, while others may not. It can result from mistakes or mere errors; some may cause harm others may not. (Emiri, 2012). Civil liability may also arise against a medical practitioner in the course of his duty and the most common and potent basis of civil liability for medical malpractice cases is negligence. (Giesen, 1988). For a plaintiff to succeed in an action on medical negligence, he must establish three essential elements which are:

(i) That the practitioner owed the plaintiff a duty of care
(ii) That the practitioner breached that duty
(iii) That the plaintiff suffered damage as a result of that breach.

In the unreported case of (Mrs Deborah Agere & Anor v Dr. S Ojobo (doing business under the name and style of Ponder End Clinic, 1994), the plaintiff claimed against the defendant the sum of one million naira in general damages as well as in negligence for the loss of the plaintiff's first male child, pains, damages, emotional and psychological depression, loss of life due to the gross reckless and negligent manner in which the defendant carried out the delivery of the 1st plaintiff's pregnancy. The summary of the facts is that, the 1st plaintiff was pregnant and when it was time for delivery, she was directed by her doctor to the defendant. The defendant requested the plaintiff to undergo an ultra-sound sensing which she did and according to her the defendant told her she could not have normal delivery as her pelvis could not accommodate the baby, so the defendant maintained he had to do a caesarean section for her. The 1st plaintiff went into labour in the defendant's hospital on the 16th June 1997. After a thorough examination, it was discovered that the baby was in distress. A caesarean section (operation) was carried out on her and thereafter the doctor suggested a blood transfusion because she had low blood packed cell volume (PCV) which she rejected on the ground of

her Jehovah's Witness faith. She left the defendant's hospital for Hope Hospital and thereafter for Gilead Hospital where a Jehovah's Witness doctor treated her without blood transfusion. The baby died three days after delivery; she then sued the defendant for negligence for the loss of her first child, pains, damages, emotional and psychological depression and loss of life due to the gross reckless and negligent manner in which the defendant carried out the delivery of her first pregnancy. The defendant denied all the allegations and denied using unsterilized equipment because he personally sterilized two sets of equipment before the operation of the 1st plaintiff. He had earlier explained that the diagnosis showed that the neck of the cervix was two (2) centimetre at 4pm and that the 1st plaintiff was in labour for one and half hours, whereas prolonged labour is one in excess of 12 hours. The defendant denied the fact that he asked the 1st plaintiff not to push if she loved herself, saying that the art of pushing out a baby at delivery for pregnant women was a reflex action. Consequently, nobody can prevent a woman at delivery from pushing. The defendant went further to say that the baby did not need oxygen. Finally, he explained that the 1st plaintiff came to him nine days after her expected date of delivery and he was not responsible for the distress of the baby, that the baby would have died in the womb if he had been in distress. The defendant said the operation was successful. The court held that there was no difficulty in holding that the defendant owes to the plaintiff the duty of care. Is there a breach of that duty of care to the plaintiff? Nothing in this proceeding so far has been presented by the plaintiff to show any breach of the duty of care owed by the defendant to the plaintiffs. Indeed, the evidence tendered through some of the witnesses of the plaintiff show that the defendant took such reasonable care and diligence in order to preserve the life of the 1st plaintiff. The plaintiffs claim was accordingly dismissed.

Criminal Liability for medical negligence

Criminal liability against health care providers aims to ensure that erring offenders are punished for negligent acts and omissions according to the law. Apart from disciplinary actions which may be taken against any medical practitioner by the Nigeria Medical Council or by an employer for negligence in the performance of his or her duty, criminal proceeding may be instituted against a practitioner by the state. The purpose or aim of the criminal prosecution is to punish the offender which could be imprisonment or the payment of fine in some cases or both. This was the position in the case of (R v Bateman, 1925) where it was held that a medical practitioner or a nurse may be criminally liable if his negligence passed beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment. Both civil and criminal proceedings can be taken against a health care provider in respect of the same wrong. For instance, where a surgeon negligently causes the death of a patient, the state can prosecute the surgeon for manslaughter and the representative of the deceased person may bring a civil action against the surgeon.

In Nigeria, two codes are applicable; they are the Criminal Code which is applicable to the Southern States of the country and the Penal Code which is applicable to the Northern part of the country. Both codes contain provisions under which medical malpractice may be charged. Under Section 343 (1) (e) of Criminal Code, where a medical practitioner gives treatment to his patient negligently, he will be charged for criminal misconduct. The basic elements of a crime include a voluntary act coupled with the appropriate mental state. Usually, the criminal law punishes only affirmative harm the offender inflicts. However, failure to act may be a crime if the defendant had a legal duty to act or the inaction rises above civil negligence to include a level of risk taking indifferent to the attendant risk of harm. In (Kim v State, 1992), it was stated however, that the degree of

negligence required is gross and not mere negligence. Under Section 303 of the Criminal Code, 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 act or by reason of any omission to observe or perform that duty.

The provisions of Section 343 (1) (e) (f) and (2) of the Criminal Code go further to state 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 or dispenses, supplies, sells administers, or gives away any medicine, or poisonous or dangerous matter, is guilty of misdemeanour, and is liable to imprisonment for one year. From these provisions, it is clear that the liability of health care providers for the negligent treatment of a patient is predicated on a breach of duty which the health care providers owe to the patient. Where, the degree of skill, care and competence required of a physician is not met in any particular case, a breach of duty may arise which could lead to criminal liability as rightly noted by a learned author (Umerah, 1989). Liability may arise not only from the doing of a positive act, for example administering the wrong treatment, but also from a negligent omission such as failing to prescribe any treatment at all. From Section 303 of the Criminal Code provided above, it is clear that not only must a health care provider who undertakes treatment of someone possess reasonable skill, the health care provider must use that skill carefully in each particular case. Conversely, if the health care provider is unskilled, it is no excuse that the best was done if the health care provider's best falls below the required standard of care. Health care providers' culpability for medical negligence can be classified into two namely:

(i) Murder/Culpable Homicide Punishable With Death: Murder/culpable homicide punishable with death is the most heinous grievous charge that can be brought against a health care provider in relation to medical negligence that results in death under Sections 316 of the Criminal Code and 321 of the Penal Code which the penalty is death. (Sections 319 of the Criminal Code and 221 of the Penal Code). In the case of (Mohammed v State, 1997), it was held that to sustain a charge of murder, it must be proved that by a person's act or omission, he intended to cause death or grievous bodily harm. The prosecution is duty bound to prove the cause of death, for if death is attributable to any other cause, then the burden of proof has not been discharged. In (Archibong Effang v State, 1968), it was held that Medical evidence may be used in the course of discharging the burden. Suffice to say that under the Criminal Code, consent to death does not affect the criminal liability of the one who causes the death. Thus, a physician who truncated the life of a patient suffering from an agonizing and terminal disease will still be culpable for murder under the Criminal Code as a result of sanctity of life, which is constitutionally guaranteed. (Section 33 of the Constitution of the Federal Republic of Nigeria,1999 (as amended).

(ii) Manslaughter/Culpable Homicide not Punishable with Death: Where death results from gross negligence in the course of doing a lawful or an unlawful act, a charge of manslaughter can be brought. Section 317 of the Criminal Code provides that any unlawful killing is manslaughter. One must note that from the outset that the degree of negligence required for a civil action in negligence is lower than that of criminal action. While ordinary inadvertence in attention or sheer carelessness is sufficient in the former, that of the latter is gross negligence.

In measuring the standard of care for negligence in medical practice, the court will be guided by the standard of an average reasonable physician, that is, what such a physician would do in the circumstances of such case. The mere fact that a patient die in the hands of someone who is not

licensed to practice medicine does not ipso facto make him negligent if he actually performed the operation skilfully as a qualified doctor would have done. In (Yaro Paki v R 1955), the accused performed tonsillectomy on his patient. The patient died six days after the operation as a result of haemorrhage and sepsis which arose from the tonsillar bed. In his evidence in court, the accused said that he had successfully performed it on 2000 people with no casualty. Despite this evidence, the accused was still convicted for manslaughter. Also in (R v Ozegbe 1957), a nurse performed surgery on the deceased. The latter bled to death. The accused was convicted of manslaughter because of his reckless disregard for human life, in that he should not have undertaken such dangerous operation knowing fully well that he did not possess the skills of a surgeon.

LIABILTY OF HOSPITALS FOR MEDICAL NEGLIGENCE OF STAFF

Ordinarily, a person who commits a tort is held liable for it. However, there are situations where a person is held responsible for the act of another person, as a result of a special relationship between him and the actor. (Nwoke, 2001). Generally, vicarious liability is a term used in describing situations in which a person is held liable for the damage caused either by the negligence or other act of another. There is no requirement that the person being held liable should have participated in the act or that he should owe a duty in law to the person suffering damage. Thus, A can be held liable for the damage caused by B to C. what is required is that A should stand in a special or particular relationship with B, and most often it is one of master and servant. The form therefore, means the case of one person taking the place of another in so far as liability is concerned.

Generally, using the criterion of control, an employer who stands in the position of authority vis-à-vis the employees is made vicariously liable for the wrong of his employee. (David Berge, 2016). This form of liability will usually arise where one employs another to perform a lawful act and that other does not perform it with the required care and skill thereby causing injury to the plaintiff. In the context of medical negligence, vicarious liability can arise from two situations which are: (i) where the employees or the doctors are negligent and (ii) where the employees, including the doctor of a hospital are negligent. The rationale for liability is said to be rooted in economic strength. It is believed that it helps spread cost, placing it on the shoulders of the party who has the economic muscle to pay. It is desirable in assuaging compensation claim to an injured plaintiff in the era of industrialisation where accidents usually occur without clear identification of the wrongdoer. (Emiri, 2012). In the past, one of the arguments for denying liability of hospital authorities was that in the actual execution of his work, the doctor or nurse is not under the control and direction of the authorities and therefore not a servant in the sense that would attract vicarious liability. This approach was particularly unhelpful, disadvantageous and highly detrimental to the plaintiff (patient) because such a medical practitioner would hardly be able to cope with the amount of damages awarded, particularly if they were substantial. The general theory in vicarious liability qui facit per alium, facit perse (He who acts through another is deemed to act in person and so, let the principal answer) now applies in medical negligence (Dada, 2018). In (Hillver v The Governor of St Batholomew 1909), the English Court of Appeal held the view that a hospital is not responsible for the negligence of its staff in the performance of their professional duties, as distinct from purely administrative duties. The rationale for this limitation is that the hospital neither dictates nor controls the exercise of professional judgment. According to the English Court of Appeal, the governors of a public hospital, by their admission of the patient to enjoy in the hospital the gratuitous benefit of its care, do I think undertake that the patient while there, shall be treated only by experts, whether surgeons, physicians or nurses of whose professional competence the governors have taken reasonable care to ensure themselves and further

that those experts shall have at their disposal for the care and treatment of the patient, fit and proper apparatus and appliances.

Going by this, a patient could sue a hospital for breach of contract or tort if the hospital does not employ competent staff or if it fails to supply to its staff proper medical equipment or is in breach of purely administrative matters. This position was a reflection of the then charitable nature of hospital treatment. The early hospitals were essentially charitable, meant for the poor as the rich could afford medical treatment in their homes. This has now changed as Hospitals are the primary institution for health care for all persons and patients not seeking charity, but highly skilled treatment. Commencing with the case of (Gold v Essex County Council 1942), the position changed. From 1942, there has been a progression in the elimination of hospitals' immunity. Consequently, hospitals became liable for the negligence of doctors, nurses and even part-time anaesthetists (Cassidy v Ministry of Health, 1951). In this respect, the courts have shifted the focus from the control criterion to one that emphasises whether the servant is a part of the master's organisation, thereby placing emphasis not on how the servant works, but rather where and when he so works. This is in response to modern social and economic realities. It thus, makes it difficult as escape route for a hospital to plead that their professional staff is free from control and supervision. As long as they are within the organisation, their negligence can be thrown on the hospital. Lord Denning in (Cassidy v Ministry of Health, 1951) summarised the law thus:

> In my opinion, authorities who run a hospital, be they local authorities, government boards whenever they accept a patient for treatment, they must use reasonable care and skill to cure him or her of his or her ailment. The hospital authority cannot of course do it by themselves; they have no ears to listen through the stethoscope and no hands to hold the surgeon's knife. They must do it by the staff they employ and if their staff are negligent in giving the treatment they are just as liable for that negligence as is anyone who employs others to do duties for him or any other corporation are in law under the self-same duty as the humblest doctor.

To hold a hospital vicariously liable either via contract or tort, the plaintiff will need to prove that (i) the person who commits the negligent act is an employee of the hospital (ii) that the act is performed in the course and scope of his employment.

COURTS AND MEDICAL NEGLIGENCE

A cursory look on grounds and reasons health care providers are found wanting for the act of medical negligence can be seen in some decisions taken by the disciplinary tribunal and courts. In the case of (Dickson Igbokwe v University College Hospital Board of Management, 1961), the deceased was admitted into a fourth floor maternity ward of the defendant Hospital Board where she gave birth to a baby on the 23rd December 1958. After the birth, she was suspected of being mentally deranged and was put on sedative drugs. A nurse was instructed to keep an eye on her. On two sides of the ward where she was admitted, there was an open veranda about seventy feet from the ground protected by railings four and a half feet high. In the morning of 29th December, 1958, the deceased was missing from her bed and was found dead from injuries she received when she fell from the fourth floor. Her dependents claimed damages for her death contending that the circumstances pointed to negligence on the part of the hospital authority and they relied on res ipsa loquitur. The hospital authority agreed under cross examination that if someone had been specially assigned to watch the deceased; the incident would probably not have occurred. No medical expert was called to show that given the case history, all reasonable precautions had been taken to prevent the occurrence. The court held that the plaintiff's action succeeded because the hospital authority had failed to rebut the inference of

negligence which arose from the facts. On the question of damages, the court did not believe that the deceased who was a petty trader contributed as much as €3 in a month towards the maintenance of her children. It awarded a sum of €250 as damages and shared it among the six children of the deceased. Her husband who was also a claimant was left out in the award because he failed to prove satisfactorily that he was married to the deceased under native law and custom.

In (Kanu Okoro Ajegbu v Dr. E. S Etuk 1962), the deceased was admitted into the Onitsha General Hospital on the 16th of August 1961 by the defendant doctor who diagnosed a ruptured appendix. He treated the deceased with antibiotics to localise the infection and performed an appendectomy on the 17th August. Only one incision was made but it had to be extended to expose the appendix properly. On the 20th August, the deceased was given an enema because his stomach was slightly distended. As it did not work, the nurse who gave it reported this fact to the defendant who instructed that a little more enema be given and if it failed, a flatus tube should be used. After the second enema which also proved unsuccessful, a flatus tube was inserted and all the enema and air were discharged. The deceased died on the 21st August. There was some evidence that the death might have been due to delayed chloroform poisoning. No post-mortem examination was performed to ascertain the cause of death. A dependent of the deceased sued the defendant under the Fatal Accidents Law claiming damages for the death which the dependent attributed to negligence on the part of the defendant. The particulars of negligence were as follows:

1. That there was gross negligence in the actual performance of the operation which was alleged to have lasted for about three and half hours and that there were two incisions.
2. That the defendant refused to attend to the deceased after the operation because he did not come into the hospital as the defendant's private patient. (A witness for the plaintiff had stated that the defendant told him that if a patient stumbled upon him officially, he would treat him officially).
3. That the deceased was overdosed with chloroform thereby setting on chloroform poisoning.

The court found that the operation lasted for about fifty-five minutes only and that only one incision was made. Even if there were two, that, according to expert testimony, would merely amount to an error of judgment. Although the administration of the first enema was a negligent act, it was not the defendant who ordered it. In any event, the enema and gas were later discharged. On the question of neglect, the court found that the evidence rather pointed the other way and there was the fact also that there were only two doctors attached to such a big General Hospital. While there was medical evidence that the symptoms before death (jaundice, restlessness and coma) were consistent with delayed chloroform poisoning, the witness was not categorical on this because as there was no post-mortem examination, it could not be ascertained whether the liver was actually poisoned. The same witness agreed that the symptoms could as well be those of paralytic ileus due to peritonitis arising from the ruptured appendix. This was the view put forward by the defendant and which the court accepted. In the result, the plaintiff's claim failed because the plaintiff had failed to prove the allegations of negligence. In (Chin Keow v Government of Malaysia, 1967), a doctor administered an injection of procaine penicillin to a woman from which she died within an hour. Her mother sued in negligence alleging that the doctor had failed to inquire or conduct any tests to ascertain whether the woman was allergic to penicillin. Had the doctor conducted the inquiry, he would have discovered that the woman had previously reacted adversely to penicillin as a result of which her out-patient card was endorsed with the warning "Allergic to Penicillin". The trial judge held that the defendant was negligent in failing to make the inquiry. The Federal High Court of Malaysia, on appeal, rejected the finding of negligence. The Privy Council restored the judgment of the trial court. The Federal Court

had taken the view that evidence should have been forthcoming from a medical witness of the highest professional standing or that such evidence as there was should have been supported by references to the writings of distinguished medical men. Their lordships of the Privy Council disagreed with this view. "The test is the standard of the ordinary competent practitioner exercising ordinary professional skill and on this the evidence was all one way".

In (Ojo v Gharoro 2010), Miss Felicia Ojo, the plaintiff in this matter needed fruit of the womb. That took her to the University of Benin Teaching Hospital. Dr Gharoro (1st defendant), a lecturer at the University of Benin and an Honorary Consultant in the Obstetrics and Gynaecology Department of the University of Benin Teaching Hospital, Benin City, examined her. Ojo was diagnosed as one having secondary infertility (uterine fibroid and menorrhagia). In other words, she was told that she had growth in her fallopian tube and that she needed a surgical operation to remove the growth to enable her become pregnant. The plaintiff needed to be pregnant and so she consented to the operation. On 17th December 1993, Dr Ejide (3rd defendant) performed the operation in the theatre of the University of Benin Teaching Hospital Management Board (2nd defendant), it is the claim of the defendants that the operation was successful. But the plaintiff thought differently. She submitted that in the course of the operation, the 1st and 3rd defendants negligently left in her womb a broken needle as a result of which she experienced great pains. She reported to the 1st defendant, who asked her to do an X-Ray. The X-Ray confirmed that there was a broken needle in her abdomen. This resulted in a second operation in January 1994, which could not totally or completely remove the broken needle. The plaintiff sued claiming the sum of Two Million Naira (₦2,000,000) as special and general damages for negligence. At the conclusion of hearing, the trial judge found that on the evidence before the court, the defendants had successfully rebutted the presumption of negligence raised by the plaintiff. The plaintiff's appeal to the Court of Appeal and the Supreme Court was dismissed. The courts held that the trial judge was correct to rule as he did.

In another recent decision of the court on medical negligence, where an FCT High Court in Maitama ordered Kings Care Hospital[1], Abuja to pay ₦1,000,000 (One Million Naira) as damages to a couple for negligence and breach of care. The claimants, Bamikole Owolabi and wife, Mercy had told the court that two ultra-scan reports by the defendant hospital showed that Mercy was pregnant with twins but gave birth to only a baby. Owolabi asked the Court to compel the private hospital to produce the second baby which the scan report showed. However, in its counter-affidavit to the suit, the hospital contended that the baby girl Mercy gave birth to is one and weighed 3.3kg, adding that it was medically impossible for a pair of babies to weigh 3.3kg. Justice Jude Okeke, however, said the hospital was negligent and liable for breach of care by issuing the claimants with scan results which did not reflect the true status of the pregnancy. Delivering judgment, the Judge held that the hospital should have conducted an independent scan to later discover that the earlier scan was wrong. Since they did not do that, the claimants still had in mind that they were going to have twins according to scan of November 21st, 2012 and March 13th, 2013 but their hopes were dashed. In the circumstances, the defendants were ordered to pay a sum of ₦1, 000,000 (One Million Naira) to the claimants for being negligent in the scan reports issued to them and ₦50, 000 (Fifty Thousand Naira) for emerging successful in the suit.

DEFENCES OF HEALTH CARE PROVIDERS

Prevention they say is better than cure. In medical negligence, prevention is the best defence. Fortunately, measures designed to prevent a doctor from being vulnerable are usually, though not invariably, also effective in improving the standard of medical practice. The standard expected by the law is that of a reasonable man or if the defendant has some special skill, for instance, a surgeon, that of a reasonably skilled surgeon in the specialty in question.

Negligence being a flagrant tort, it is important to examine the defences available to health care providers to an action in it. There are six major defences to an action for negligence. They include contributory negligence i.e. where the plaintiff's fault contributed to the damage suffered by him and damages awarded are reduced in proportion to his fault. The second is mistake as it is expected of every health care provider to be properly trained and diligent when handling patients. Accident is another form of defence. No human on earth is free from accident as accident may happen sometimes due to no fault of the defendant. Emergency is another defence, as medical treatment provided in emergency situations i.e. Accident scene cannot be compared with one provided in a conducive situation. Novus Actus Intervenies is another situation whereby an event might have occurred which is beyond the health care provider and where a patient decides to waive the duty of care owed to him. This is referred to as voluntary assumption of risk.

Contributory Negligence: Contributory negligence cannot be precisely defined. It has both legal and factual meanings. In legal parlance, it is the negligence of the injured party, which contributed even in slightest degree to his damage. It is the failure of the plaintiff to use due care to avoid reasonable foreseeable harm to himself. (Nwoke, 2001:175).

Just as the health care provider is under a duty to take reasonable care in the treatment of the patient, the patient is also under certain duties to the health care provider. He must be reasonable. If he is not and his unreasonableness is the factual and proximate cause of his injury, he would be treated as having contributed and his compensation will be reduced. Accordingly, in (Crossman v Stewart, 1977) the British Columbia court reduced the compensation of the patient to €26,666 from the sum of E80,000 assessed damages for injury that resulted in his blindness because it found that the patient had two-thirds of the blame. She obtained the prescribed drug from an unorthodox source and used them longer than prescribed. In (NRC v Emeahara & Son, 1992), it was held that the onus of proof is on the defendant to raise the defence of contributory negligence. In this defence, the medical practitioner would have to prove that it was basically the negligence of the plaintiff himself which combines with his in bringing about the actual damage. On this, it is apparent that:

A person is guilty of contributory negligence if he ought reasonably to have foreseen that, if he did not act as a reasonable prudent man, he might be hurting himself and in his reckonings he must take into account the possibility of others being careless (Jones vs. Livox Quarries, 1952).

Mistake: Health care providers sometimes do make serious errors because of poor judgments, inexcusable negligence, and lack of immediate care or focus on the wrong ailment. Though many patients being treated on a daily basis are satisfied with the care they receive, on a few occasions, inevitable mistakes capable of making an enlightened and aggrieved patient to demand huge claims do happen. Most settled medical negligence claims involve medical error or misdiagnosis and these claims most times, do run into millions of Naira. When a health care provider fails to perform his or her duties with the same standards and skills that one would normally expect of such a professional, medical malpractice may have occurred. Some medical implications do arise due to extenuating circumstances with certain medical conditions; there simply is nothing that a medical practitioner can

reasonably do to improve the situation. Thus, a medical malpractice case cannot arise due to the patient's supervening conduct; neither does it include novel treatment methods where such treatment is consistent with generally accepted practice (Olokooba & Ismail,). Whatever may be the justification for mistakes, regardless of whether the negligence is gross or simple, they are always unacceptable and punishable by law if such victims complain. For instance, at different times every year, the Nigerian Medical and Dental Tribunal conduct the trial of several doctors for professional negligence and misconduct. Liability is usually reserved for cases where mistakes and negligence could have been prevented in the absence of human error or lack of skill. A finding of medical error is required in order to find liability and accordingly, a deviation from what would generally be expected by a doctor is required to be found. However, a distinction has to be made between medical mistake which is excusable in law and mistake which will constitute negligence. In medical mistake, the law regards as excusable. This is because the court accepts that ordinary human fallibility precludes liability while in mistake that constitutes negligence. The conduct of the defendant is considered to have gone beyond the bounds of what is expected of the reasonably skilful or competent doctor. In (Whitehouse v Jordan, 1981), the court stated thus, 'the true position is that an error of judgment may, or may not be negligent, it depends on the nature of the error'. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having and acting with ordinary care, then it is negligence. If, on the other hand, it is an error that such a man, acting with ordinary care, might have made, then it is negligence. It should be noted that gross mistakes are always treated as medical negligence. In the light of the above, in order for the plaintiff to establish negligence in a case of error in the course of treatment, he must succeed in answering these two questions:

(1) Whether the defendant made a mistake as adjudged by the circumstance in which he was acting.
(2) If so, whether the mistake was one which a reasonably careful and skilful medical practitioner would not have made.

The plaintiff must of course succeed in both questions in order to establish negligence. Another practicable example of human error is in the unreported case of citizen Buba of Bauchi State, whereby a doctor allegedly removed his two kidneys and bolted away. The victim whose health deteriorated was thereafter reportedly referred to the Aminu Kano University Teaching Hospital (AKUTH) Kano by Aminchi Hospital management, even when there is a teaching hospital in Bauchi. Scanning at Aminu Kano University Teaching Hospital showed that Buba's two kidneys had been removed and he was immediately placed on dialysis and later referred to Abubakar Tafawa Balewa Teaching Hospital Bauchi where he fought the battle of his life. Such a case will and cannot be referred to as mistake on the part of medical negligence due to the fact that an act cannot be said to be one which reasonable, careful and skilful medical practitioner would have made, therefore such an act will be treated with criminal consequences.

Furthermore, in the unreported malpractice case in an Ohio hospital, a recent admission by the University of Toledo about what happened at its hospital is a very good example of mistake in medical negligence. However, mistake cannot be use as a defence open to medical practitioners and hospitals in this case as something was definitely missing in the chain of events that characterize the hospital system of kidney transplant in Ohio. In this case, human error or mistake as the case may be led to a woman not being able to receive a kidney transplant from her brother. According to reports, a nurse threw the kidney after it had been removed from the man. The organ could not be used at the time the error was discovered. The man's sister who had end-stage renal disease was already in the

operating room. This singular act will not only lead to traumatic injury but will also cause the woman a lot as she will now have to go back onto the waiting list for a match and in such wait, anything can happen which can not only lead to permanent injury or death.

Accident: This defence will avail a defendant where although damage has resulted from his action, he is neither negligent nor intended damage. The case of (White v Board of Governors of H.W) (Dada, 2018), a surgeon cut the retina of a patient accidentally during an eye surgery. It was held that since the surgeon was operating within a very few millimetres and had exercised all reasonable skill, care and judgment, he was not liable for negligence. Hence the defence of accident will avail a defendant who caused damage to a plaintiff, either because he was neither negligent nor intended the damage. Since a great deal of medical treatments carry with them a high risk degree, even when they are skilfully and carefully carried out, the defence of accident is naturally the most common defence in medical negligence.

Emergency: A medical practitioner may be absolved of all liability where he renders emergency care at the scene of an accident, for instance, even where it is shown that the normal requisite care and skill had not been shown or exhibited in the circumstances. Where he gives extra treatment than is necessary in the circumstances, he will be held liable if injury results therefrom. Good Samaritan laws may exist in other parts of the world but it does not apply in Nigeria. Thus, the medical practitioner in such cases will be held liable to the degree of care of a reasonable medical practitioner in the circumstances. It appears therefore, that the defence in Nigeria will not be exactly as it is in United States and other jurisdictions.

Novus Actus Intervenies: Where someone or an event or an act intervened between the negligent acts of the health care provider and the consequent injury which is the basis of the patient's complaint, the health care provider can raise a defence, except such intervention did not break the chain of events. This means that without the happening or occurrence of the intervening factor, the injury complained of would not have happened but that things would have been normal. The intervening factor is what changed the happening of events thereby deviating from normal.

Voluntary Assumption of Risk: Where the plaintiff agrees, expressly or impliedly to waive the duty of care owed to him, it may be relevant in determining negligence though the court will generally be reluctant to use it as a reference considering the inequality of power relation in the doctor-patient relationship. It can even be argued with justification that the very nature of medical care underlined by public policy considerations ought to refuse voluntary assumption of risk as a defence to an action for negligence. (Emiri, 2012). Any such waiver should be treated as striking at the root of the essence of care and so should not be considered a defence at all, for if it were otherwise it can destroy the very soul of medical care.

Methodology

This study employed the survey research method in generating data which the researchers deemed appropriate for the study of a large population of people on the awareness of legal remedies for liability arising from medical negligence caused by health care practitioners and facilities. The survey research method was used due to the representative result it gives based on a sample drawn from the entire population (Nwodu, 2006) The population of the study is 1,024,000 comprising all the residents of the seventeen local government areas of Plateau state within the age distribution of 30-80 years and above according to the Plateau State, Nigeria- Population Statistics, Charts, Map and Location. A sample size of 385 was arrived at after the application of the Wimmer and Dominick online sample size calculator using a confidence level of 95% and precision level of 5%.

Data Presentation, Analysis and Discussion

Research Question One: To what extent are the residents of Plateau State, Nigeria aware of the legal remedies for medical negligence?

Response	Frequency	Percentage
To a large extent	30	8%
To some extent	57	15%
To no extent	281	73%
Can't say	17	4%
Total	385	100%

The finding from the above table shows that out of 385 respondents, 30 respondents or 8% said that they are aware of the legal remedies for medical negligence to a great extent, 57 respondents or 15% said that they to some extent know about the legal remedies for medical negligence, 281 of the respondents or 73% stated that they know nothing about the legal remedies for medical negligence while 17 or 4% of the respondents said nothing. It is obvious from the data presented above that majority of the respondent do not know that health care practitioners and facilities can be held liable under the law for medical negligence committed against any patient.

Research Question Two: How willing are the residents of Plateau State, Nigeria who are aware of the legal remedies for medical negligence, to enforce their rights against health care practitioners and facilities for medical negligence?

Response	Frequency	Percentage
Very much willing	47	12%
Not willing at all	296	77%
Can't say	42	11%
Total	385	100%

The table above aimed at finding out the willingness of respondents towards taking legal steps for the enforcement of their rights if faced with a situation caused by the negligence of a health care practitioner or health care facility. The results indicated that 47 or 12% of the respondents are very much willing to pursue legal actions for medical negligence while 296 or 77% of the respondents stated their total unwillingness to embark on such legal ventures. 42 or 11% of the respondents were undecided.

Research Question Three: What factors impede the enforcement of legal rights in medical negligent cases in Plateau State, Nigeria?

Response	Frequency	Percentage
Reluctance due to corruption in the judicial system	105	28%
Delay in court processes	75	19%
Poverty	95	24%
Ignorance and illiteracy	110	29%
Total	**385**	**100%**

The table above sought to elicit from the respondents some of the factors which might hinder them from adopting legal measures for the enforcement of their rights in situations where medical negligence is perceived to have arisen. From the table, 105 or 28% of the respondents were of the view that they are reluctant to adopt legal measures in such cases due to the spate of corruption in the judicial system, 75 or 19% of the respondents attributed their inability to embrace legal actions against health care practitioners and facilities for acts amounting to medical negligence to incessant delays which characterise court processes in Nigeria. 95 or 24% of the respondents said that they are discouraged from approaching the courts in the event of medical negligence as a result of poverty, while 110 or 29% of the respondents said that ignorance and illiteracy are the major factors which deter them from going to the courts for the enforcement of medical rights.

Discussion of Findings

The first research question was meant to find out the extent to which the residents of Plateau State are aware that there are legal remedies available against health care practitioners and facilities in the event of medical negligence committed by them. The survey revealed that a majority of the sampled respondents are oblivious of the remedies which may be resorted to when a health care practitioner or facility commits an act or an omission amounting to medical negligence. This finding correlates to the observation made by (Abugu and Obalum). According to them, in order to improve the level of medical malpractice claims in Nigeria, there should be sufficient instructions and training to legal practitioners who are expected to transmit same to the unlearned minds of the members of the

society. The finding of this research question is also similar to the finding of (Enemuo, 2012). The writer stated that many people in Nigeria do not know their rights and that it is when patients become better informed of their rights that the quality of health care in Nigeria can be improved.

The second research question was designed to ascertain the willingness of the residents of Plateau State, Nigeria to embrace legal measures for the enforcement of their rights in medical negligent cases against health care practitioners and facilities. The survey found that a greater percentage of the sampled respondents expressed total unwillingness to initiate legal measures against erring heath care practitioners for medical negligence. This result is similar to that of (Ibitoye, 2018) who stressed that notwithstanding the magnitude of negligence in the Nigerian health care system, citizens do not initiate litigations against guilty practitioners.

The third research question sought to elicit from the respondents the factors which inhibit them from using legal means to address incidences of medical negligence perpetrated against them by health care practitioners and facilities. The result revealed that a majority of the sampled respondents pointed out ignorance and illiteracy as the major restraints on the enforcement of medical rights. This result corroborates the finding of (Ogundare, 2019) who expressed that in spite of the large number of victims of medical negligence in Nigeria, the number of cases filed as lawsuits is low due to poverty, illiteracy, ignorance and reluctance to seek redress against medical practitioners.

CONCLUSION AND RECOMMENDATION

This study found that a majority of the residents of Plateau State, Nigeria are not informed about the legal remedies for medical negligence against health care practitioners and facilities. The study further revealed that a greater percentage of the sampled respondents are not willing to pursue legal actions against health care practitioners and facilities in the event of medical negligence largely due to illiteracy and ignorance, reluctance as a result of corruption in the judicial system, poverty and delay of court processes. The research therefore, recommended that the government and other non-governmental agencies should vigorously educate both the learned and unlearned members of the society on their medical rights such as the right to maintain law suits against negligent health care practitioners and institutions. It is also recommended that the justice system in Nigeria should be effectively overhauled with a view to eliminating corruption and unnecessary delays which scare prospective litigants away from the courts; and that the government should strive to eradicate poverty and also create an enabling environment which will encourage legal practitioners to offer pro bono representations on behalf of victims of medical negligence.

CONFLICTS OF INTEREST

There are no conflicts to declare.

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