

# **Medical Negligence Litigation in Nigeria: Identifying the Challenges and Proposing a Model Law Reform Act**

A Thesis submitted to the Trinity College, Dublin in fulfilment of the requirement of the award of the Degree of Doctor of Philosophy

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2017

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## **DECLARATION**

I declare that this thesis is entirely my own work and has never been submitted for any degree or examination in any university.

**DATED:**

**SIGNED:** \_\_\_\_\_

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## **Abstract**

This thesis examines the present law and practice of Nigeria in relation to medical negligence litigation and makes proposals for reform. The present position is highly problematic. There are major shortages in medical resources in hospitals. There has been a “brain drain” of doctors and nurses from Nigeria to richer countries. The cultural and religious attitudes in parts of Nigeria tend to weaken the assertion by patients of their rights.

A further difficulty is the absence of reported case law and the very limited academic analysis of the subject. As a matter of both international human rights law and constitutional law, it is necessary that Nigerian law on medical negligence should be reconstituted and codified. For this reason, the thesis contains a Model Act, designed to reflect the best insights of lawyers throughout the world but, more particularly, to take account of the indigenous factors in Nigeria – resource limitations, religious beliefs, cultural attitudes to gender and autonomy, for example – so that the legislation will represent best practice for Nigeria rather than some theoretical model for reform.

The thesis thus examines in considerable detail the constitutional and international human rights aspects of the protection of the right to health, as many of the deficiencies in the delivery of healthcare in Nigeria are attributable to failures at governmental level.

The thesis seeks to provide a solution to the limits of private law claims by proposing a hybrid model whereby courts in medical negligence litigation should have some role in providing a remedy for egregious governmental failure to vindicate patients’ right to health.

Under the law in every common law jurisdiction, including Nigeria, the concept of the duty of care in negligence does not extend to matters falling within the proper remit of democratic resolution through the political process. Thus, it is not possible to sue the Minister of Health in negligence for having provided inadequate resources to healthcare. That is essentially a political question. Yet international human rights law and the Nigerian Constitution (less clearly) impose binding obligations in regard to the protection of the right to health. The Model Act proposes that courts in negligence litigation should be permitted to have some regard to this public law dimension and to award compensation to injured patients, in cases of neglect of the minimum core obligations to protect the patient's right to health, exercising that jurisdiction in a restrained manner, respectful of the separation of powers.

## **Acknowledgments**

First and foremost, the credit of my research goes to my supervisor, Prof. William Binchy who is worthy of commendation. As a result, I thank him sincerely for his continued support and contribution to my achievements generally.

I am also grateful to Prof. Neville Cox, the Dean of Graduate Studies, Trinity College Dublin for his magnanimous assistance and support for the completion of the thesis. I thank Prof. Alex Schuller and other academic staff through whom I passed in postgraduate studies for their brilliant and high scholarship.

My gratitude also go to the non-academic staff, particularly Catherine Finnegan, Kelly McCabe, Mairead Morrissey and Anne Burke whom I hold in high esteem for their kindness and approach at all material times.

At family level, I am grateful to Ambassador Olu Otunla who first advised me to pursue a postgraduate studies in Trinity College Dublin, which it came to pass with a huge success today. I acknowledge my loving father, Pa Johnson Akinola Komolafe, my mother of blessed memory, Mrs Abigael Olabanji Komolafe, Prof. Isaac Olakanmi Abimbola & Mrs Comfort Nihinlola Abimbola, Pastor Kehinde Fadipe & Mrs Rebecca Fehintola Fadipe, Mr Robert Olatunbosun & Mrs Rachael Oluremi Olatunbosun and the entire family of Gabriel Adejuwon for their best wishes, contributions and prayers.

I am indebted to Prof. Yemi Kayode-Adedeji, Prof. (Mrs) C. A. Agbebaku, Funmi Gloria Adeyemi, Audrey Thomas and Dr. Bolanle Omoniyi for their professional advice and encouragements. I thank my friends generally, and in particular; Bayo Famofa, Sunday Oluborode (aka Shadowman), Niyi Adekanle, Banji Famurewa, Grace Adetutu, Shammeh Hammed, Bolanle Adeleke and Taiwo Ajayi who have been supportive in different ways.

I owe great thanks to my children for their endurance and wishing them a successful life in their chosen career. I would also thank Olukemi Susuana

Komolafe, Esther Ayoni Komolafe, and Dr. Tina Ehis Ehighalua for their dedication and prayers.

Lastly, I give all the glory to almighty God who made everything possible and through Him I succeeded.

## **Dedication**

This thesis is dedicated to my supervisor as a mark of respect for his contribution to the development of law.

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## Chapter One

# Medical Negligence Litigation in Nigeria: Identifying Challenges and Proposing a Model Law Reform Act.

### *Introduction*

In this thesis, I examine the present law and practice of Nigeria in relation to medical negligence litigation and make proposals for reform. The present position is highly problematic.<sup>1</sup> There are major shortages in medical resources in hospitals. There has been a "brain drain" of doctors and nurses from Nigeria to richer countries. The cultural and religious attitudes in parts of Nigeria tend to weaken the assertion by patients of their rights.

A further difficulty is the absence of reported case law and the very limited academic analysis of the subject. As a matter of both international human rights law and constitutional law, it is necessary that Nigerian law on medical negligence should be reconstituted and codified. For this reason, the thesis contains a Model Act, designed to reflect the best insights of lawyers throughout the world but, more particularly, to take account of the indigenous factors in Nigeria – resource limitations, religious beliefs, cultural attitudes to gender and autonomy, for example – so that the legislation will represent best practice for Nigeria rather than some theoretical model for reform.

It may be useful, at this very early point in the thesis, to mention a number of preliminary matters. First it is necessary to provide the context for the research. There is a considerable body of empirical evidence that the provision of healthcare in Nigeria suffers from serious deficiencies. Mortality rates are strikingly high and there is recurrent evidence of failure to provide safe care for patients, by reason of

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<sup>1</sup> Nigeria is not alone in this aspect. See Nathan Cortez, *A Medical Malpractice Model for Developing Countries?* (2011) 4 Drexel L Rev 417.

poor decision-making at a macro level and inefficiencies and neglect at a micro level. It is dangerous to be a patient in Nigeria. There is a real risk of death or injury from the inadequacies of the health system in its basic organisation and in the specifics of its delivery in individual cases.

The avenues for recovery of compensation for medical negligence in Nigeria are essentially those of the common law. The Nigerian tort law system is largely the same as that operating in Britain, Ireland, North America and Australia. The Nigerian courts are conservative in their application of tort principles. There is little evidence of any developed theory of the role of tort law in Nigerian society. Instead, there is a tendency towards formalism, disguising – or, more probably, ignoring – any analysis of underlying policies.

Tort law in Africa generally suffers from this vice of formalism at the expense of policy analysis. Academic research on African tort law is still at a very basic and unimpressive stage. Africa has no equivalent to Winfield, Prosser or Fleming.

This thesis seeks to provide a new level of research and analysis. Research for the thesis has been conducted on the law on medical negligence in the developed legal systems of Britain, Ireland, North America and Australia as well as throughout Africa. The thesis seeks to incorporate into an African, and specifically Nigerian, analysis the fruits of research into these developed legal regimes.

The thesis also seeks to propose answers to the questions that should confront the Nigerian courts in coming years: What should be the approach of Nigerian courts to the standard of care of medical personnel? What requirements should there be regarding the informed consent of patients to proposed treatment? How should the courts respond to the manifest inadequacies in resources, even to the most basic requirements for needles and gloves? And should the extension of liability to

healthcare institutions based on broad notion of vicarious liability and direct, non-delegable, liability be incorporated into Nigerian law?

The easy solution would be to advocate in favour of adoption by Nigeria of the most advanced liberal positions that have found a foothold in Britain, Irish and North American society. The thrust of this thesis, however, is not to engage in an automatic application of these contemporary liberal norms but rather to seek to propose more subtle solutions, sensitive to the cultural complexities and socio-economic realities of contemporary Nigerian society. This means that one has to address, not what one would wish, in the abstract, to see encapsulated in Nigerian tort law, but rather what would offer the best practical solution, consistent, so far as practicable, with the requirements of international human rights standards.

Consideration of international human rights standards brings us to a most important issue that emerges from the research. One must conclude that a victim of medical negligence in Nigeria is not likely to succeed in a claim for negligence under conventional tort law principles, for several reasons: the difficulty of adducing expert evidence; the application of a conservative test for determining professional negligence, and difficulties in regard to proof and causation. However, a claim in public law, based on international human rights standards, as accepted by Nigeria, would in principle stand as good chance of success.

One must retain a practical grasp of the realities of Nigerian life in this context. Tort litigation presents formidable challenges for the victims of medical negligence. It is very hard to find expert witnesses who are willing to testify that the practices adopted by their Nigerian colleagues should be stigmatised as negligent. Lawyers' costs are substantial. The cultural response to accidents

generally and medical misadventure in particular is non-judgmental and stoic.<sup>2</sup> Tort plaintiffs tend to be regarded with some suspicion, as though they are seeking to derive an opportunistic advantage.

Litigants in the area of human rights and constitutional law are perhaps not regarded with quite as much suspicion but they face a different hurdle, which is that such claims are formidably difficult to win and, even when successful, yield either no compensation (as where a declaration of breach is rightly the outcome) or very low amounts of compensation.

Thus, those who have been injured by the operation of healthcare system in Nigeria are faced with an unpalatable choice, offering two avenues of potential recovery, neither of which is likely in practice to result in adequate compensation: a tort claim in medical negligence against the healthcare institution, which will almost certainly be defeated by application of the professional negligence standard, the requirements of expert evidence and the legal barrier of causation, or a claim against the state of Nigeria, which will be actively defended by employees of the state and is likely, at best, to result in a declaration of a breach by the state of Nigeria of its international law obligations but no substantial recompense for the damage caused to the victim or the victim's family.

Against this harsh reality, the thesis makes a series of recommendations as to the future development of the law on medical negligence claims in Nigeria. These recommendations are not likely to commend themselves to those who favour the advanced culture of individualist autonomous choice which characterises the academy, and increasingly the courts, of North America, Britain, Ireland and

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<sup>2</sup> Cf Ezeome & Marshall, *Informed Consent Practices in Nigeria* (2009) 9 *Developing World Bioethics* 138, at 140: "The general reticence to use litigation in settling medical disputes is said to be embedded in the Nigerian sociocultural milieu .... Nigerians will prefer to 'leave the judgment to God' rather than take steps to seek redress in courts."

Australia. It is the respectful submission of the author of this thesis that, in order to promote reforms in the law in Nigeria that have a sensitive prospect of endorsement by the Nigerian courts, it is necessary to have regard to the *realpolitik* of Nigerian society. There is no point in advocating changes that resonate in a culture that is alien to the situation that prevails in Nigerian today.

A similar approach is adopted in this thesis in regard to setting professional standards of healthcare. The task for the courts is to articulate rules of conduct that can be achieved in contemporary Nigeria, which will improve the level of care given to patients. Courts must strike a difficult balance between articulating an impossible standard – which clearly cannot and will not be implemented in practice – and, on the other hand, acquiescing in a culture of carelessness and neglect. Thus, for example, there are sound reasons why the Nigerian courts should contemplate adopting a version of the “locality rule”, long rejected by most courts in the United States of America, since it may be the best way of taking account of different levels of resources and expertise as between the best hospitals in Abuja and Lagos, for example, and a small local hospital deep in the country, hundreds of miles from metropolitan centres of excellence.

### *Methodology: Challenges Confronting Research*

It may be useful at the outset to mention some of the challenges that confront research for this thesis.

The first is the relative inaccessibility of caselaw. Nigerian judgments are not electronically accessible on a public website such as BAILII or SAFLII. There is a limited amount of commercially-driven electronic materials but one has largely to rely on traditional hand-copy law reports. Many of the law reports series in Nigeria have been of short duration, petering out after a few years. *The Nigerian Weekly*

*Law Reports* (NWLR) has been more long-lasting. Its coverage of medical negligence cases is, however, limited.

This limitation reflects the fact that in Nigeria, as indeed in other African states, medical negligence is rarely the subject of litigation. As has been indicated above, there are many reasons for this dearth of cases: medical negligence claims are hard to prove; expert witnesses are few on the ground and expensive to recruit; the test for determining professional negligence is not easy to surmount; causation may be hard to establish even where negligence can be proved; moreover, the courts show little sympathy for the challenges facing patients and generally apply traditional, conservative principles in a somewhat mechanical way.

As has also been mentioned, there are further difficulties facing litigants: tort law in Nigeria has never been analysed at a high academic level, so judges have no significant guidance from the scholarly community as to how best to resolve complex issues. The supply of foreign torts textbooks in the law libraries of the courts is deficient: old editions are frequently cited by the courts without any apparent appreciation that the law in England, North America or Australia may have changed in recent years.

One should also have regard to cultural and social realities in Nigeria. The majority of the population is poor and most people are unable to contemplate litigation in the courts, even if aware of their entitlement to one.<sup>3</sup> There is no developed system of civil legal aid. Judgments are not easy to enforce. Corruption affects many aspects of public life, including the judicial system. Far from there being a "compensation culture" in Nigeria, as has been indicated already, there is a cultural reluctance to litigate for compensation for torts. Injuries, even when caused by negligence, tend

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<sup>3</sup> Halima Doma, *Enhancing Justice Administration in Nigeria through Information and Communications Technology* (2016) 32 J Marshall J of Info. Tech. & Privacy L 89, at 95-96.



to be regarded as part of the vicissitudes of life, possibly divinely ordained: to seek compensation can be regarded as violating the natural and supernatural order rather than as vindicating one's rights.

Research for this thesis was conducted in the libraries of Trinity College Dublin, Nigerian Law School (Lagos Campus) and Obafemi Awolowo University (OAU), Ile-Ife, Nigeria, as well as through electronic media. An attempt has been made to include analysis of the law, not only in Nigeria but in other African States. The common law system prevails in Nigeria, Ghana, The Gambia, Uganda, Kenya, Tanzania, Malawi and Zambia, as well as in the common law region of Cameroon (which sadly yielded no relevant materials on medical negligence). In South Africa and other states in Southern Africa – Botswana, Lesotho, Swaziland, Zimbabwe and Namibia – the Roman Dutch system applies. This is conceptually different from the common law but its rules relating to medical malpractice tend to result in outcomes very similar to those of the common law and courts in these jurisdictions are frequently willing to cite relevant judicial authorities from common law jurisprudence.

The civil law system applies in those African states that are former colonies of France. By virtue of the emphasis on the Civil Code and the relatively inferior status of court judgments, there was not any significant jurisprudence on medical malpractice emerging from these African states.

The thesis is also based on detailed research relating to the law in common law jurisdictions where medical negligence litigation is at an advanced state of development – the United Kingdom, Ireland, Canada, the United States of America and Australia.

As has been already indicated, the task for this thesis is to abstract what is best from this body of international jurisprudence apply it to the specific context of

Nigeria so as to yield results that are likely to be capable of implementation in Nigeria, to the benefit of patients, finding the *via media* between theoretically attractive reforms which have no prospect of practical implementation in Nigeria, on the one hand, and acquiescing in a culture of unacceptably low standards of healthcare on the other hand.

### *The Public/Private Divide*

It may be useful at this point to refer to the public/private divide which I have already mentioned. Traditionally, negligence litigation is regarded as falling clearly within the remit of private law, quite separate from public law matters such as human rights and constitutional law.

The main reason for this is that the Nigerian healthcare system suffers from profound defects at the macro level – shortage of doctors and nurses, poor infrastructure, lack of resources and political corruption – which impact at the micro level of care for individual patients. A patient who dies because he or she does not receive a blood transfusion may have lost his or her life in circumstances where the hospital cannot be successfully sued for negligence as the question of resource allocation from the Ministry for Health has such a political component as to place it outside the remit of the duty of care. Just as in Britain or Ireland, for example, a claim in negligence against the Minister for Health for inadequate allocation of resources to the health sector will fail on "policy" grounds, so also in Nigeria it is clear that such a claim will founder. The deceased patient's family will thus not be able to vindicate the breach of his or her rights (to life, health and bodily integrity) through the medium of a private law claim.

But the possibility of a claim within the *public* law domain remains. The family may, for example, invoke the African Charter on Human and Peoples' Rights

(which has been incorporated into Nigerian law). The family's prospects of success are thus stronger in public law than in private law.

Accordingly, this thesis examines in some detail this public law dimension. Against the background of the deficiencies in the tort law system, it is appropriate that human rights and constitutional law claims should be closely scrutinised. Here one encounters an interesting contrast in the quality of the jurisprudence. Whereas, tort law in Nigeria and most other African states is undeveloped and unimpressive in the lack of intellectual rigour that has been applied to it, human rights and constitutional law have attracted intellectual engagement, by courts and scholars alike.

One must return to the stark reality that litigation in the area of human rights, even if successful, is unlikely to result in adequate compensation for the victim of medical negligence. The fact is that the present legal regime in Nigeria is not structured to afford an appropriate remedy for such failures in healthcare. The draft legislation which I propose at the conclusion of this thesis is designed to deal, so far as practicable, with this dilemma.

Before examining the specific aspects of negligence litigation against healthcare providers, it is necessary, therefore, to set out the empirical realities of healthcare provision in Nigeria and to examine the public law and international understanding of the right to health.

## **Chapter Two**

### **The Healthcare System in Nigeria**

#### *Introduction*

In this Chapter, I examine the healthcare system in Nigeria. As already been indicated, the present position is far from satisfactory. Nigeria, in spite of having considerable natural resources, has huge inadequacies in the delivery of healthcare. One should have regard to the broader picture.

Millions of people around the world do not have access to essential treatment and medication for many diseases.<sup>4</sup> The World Health Organisation (WHO) has observed that '[e]ssential medicines save lives and improve health when they are available, affordable, of assured quality and properly used. Still, lack of access to essential medicines remains one of the most serious global public health

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<sup>4</sup> Maureen Bezuhly *et al*, *International Health Law* (1973) 31 *International Law* 645, at 657.

problems.<sup>5</sup> It estimates that about 30% of the world's population lacks regular access to essential medicines; in the poorest parts of Africa and Asia. HIV/Aids treatment takes the largest proportion but the latest report recorded a progressive decline of infection.<sup>6</sup> The epidemic that emerged recently, particularly in some African countries<sup>7</sup> is the Ebola virus disease (EVD) (formerly known as Ebola haemorrhagic fever). The World Health Organization has characterised its outbreak as a "public health emergency".<sup>8</sup>

The Nigerian healthcare system is a weak public/private hybrid<sup>9</sup> designed on a narrow planning and implementation without adequate information as guiding

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<sup>5</sup> WHO (2004), *Equitable access to essential medicines: a framework of collective action*: (WHO Policy Perspectives on Medicines, March 2004).

<sup>6</sup> Global Report: UNAIDS Report on the Global Aids Epidemic (2010) 1, at 8, notes: "In 33 countries, HIV incidence has fallen by more than 25% between 2001 and 2009. Of these countries 22 are in sub-Saharan Africa. The biggest epidemics in sub-Saharan Africa – Ethiopia, Nigeria, South Africa, Zambia, and Zimbabwe – have either stabilized or are showing signs of decline. However, several regions and countries do not fit the overall trend. In seven countries, five of them in Eastern Europe and Central Asia, HIV incidence increased by more than 25% between 2001 and 2009. These figures demonstrate that positive behaviour change can alter the course of the epidemic – while stigma and discrimination, lack of access to services and bad laws can make epidemics worse. In both cases, the effects are often profound."

<sup>7</sup> Hunter Walker, *Business Insider* (9 August 2014), noted: "According to the WHO, the current Ebola outbreak began in Guinea last December and has since spread to Liberia, Sierra Leone and Nigeria. As of August 4, the WHO statement said there have been 1,711 reported cases of the disease, over 1,000 of which have been confirmed, and 932 deaths due to the virus." WHO: Disease Outbreak News, *Overview of ongoing outbreaks: Ebola Virus Disease in West Africa* (2014) 4(4) Outbreak Bulletin 1, at 3, states: "In the past seven months, the Ebola Virus Disease outbreak in West Africa has affected six countries namely Guinea, Liberia, Sierra Leone, Nigeria, Senegal and Mali. As of 27 October 2014, a cumulative total of 12,328 cases and 4,489 deaths was reported ... 4% of the cases 6% of the death were reported among healthcare workers (522 cases and 295 deaths). Guinea, Liberia and Sierra Leone continue to report high numbers of cases and deaths. The outbreak is widely spread over large geographical areas with intense transmission ... Mali reported its 1<sup>st</sup> case on 23 October from Kayes district, bordering Mauritania and Senegal. The index case is a 2 years old child who travelled with her grandmother from Conakry, Guinea to Kayes, Mali. 82 contacts have been identified and are under follow-up. Nigeria reported 20 cases including 8 deaths and Senegal 1 case with 0 death. Senegal and Nigeria have declared an end of Ebola outbreak on 17 and 20 October, 2014 respectively."

<sup>8</sup> Hunter Walker, *Business Insider* (9 August 2014), quoted the resolution of WHO, stated: "The possible consequences of further international spread are particularly serious in view of the virulence of the virus, the intensive community and health facility transmission patterns, and the weak health systems in the currently affected and most at-risk countries."

<sup>9</sup> National Strategic Health Development Plan Framework: Health Sector Development Team (2009-2015) 1, at 23, acknowledged that health care services in Nigeria are provided by a multiplicity of health care providers – public, private including for profit and not-for-profit, patent medicine vendors and the traditional health care providers. It states: "Despite considerable investment in the health sector over the years, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system. Consequently it is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA

principles before decisions are made by the policy makers. The system still operates on the manual recording of information data of patients, including birth and death registration, and has yet to adopt a general practice of computerized information systems current in the modern world.<sup>10</sup> It is also interesting to observe the pluralistic nature of Nigeria's health system with the orthodox and traditional medicine operating along-side each other without competition, albeit with hardly any collaboration.<sup>11</sup> Rather than engage in a cultural civil war, orthodox and traditional medicine have come to a silent truce, each system effectively ignoring the existence of the other.

Nigeria's National Health Policy, revised in 1996,<sup>12</sup> places much emphasis on primary healthcare under local government as it is contained in the Fourth Schedule

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and Ward levels. For example, the proportion of PHC facilities providing immunisation services range from 0.5% in the North-West Zone to 99% in the South West and South East Zones. Also the capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide this service. This limited coverage of basic health services, which results from poor access to information and services result in under utilisation of services.”

<sup>10</sup> Makanjuola Akande, *Population with ill-health burden; faced with a sick health system*, "142<sup>nd</sup> Inaugural Lecture at University of Ilorin, Kwara State, Nigeria" (13 February 2014), at p 24-25, states: "Policy makers, managers and care providers require adequate information on which to base decisions. The Health Information System in most developing countries fails to provide adequate support for health planning and management. In Nigeria, some of the factors militating against an effective National Health Management Information System (NHMIS) include lack of coordination and poor infrastructure. Collection, collation, analysis and interpretation of data in health facilities particularly primary health centres are often unsatisfactory. In Nigeria, the limited available health data largely originate from health facilities whilst it is well known that a high proportion of people patronize the private health facilities. The data from private health facilities is largely not captured within the NHMIS. ... Information support for effective health care planning and implementation is a major challenge in Nigeria. At all operational level; the home, the community, the health centre, local, state and federal government, health information management is critical.”

<sup>11</sup> Toyin Adefolaju, *Traditional and orthodox medical systems in Nigeria: The imperative of a synthesis* (2014) 2(4) *American J of Health Research* 118, at 119-120, remarks: "Both traditional and orthodox health systems have been developed to enable the people to meet their health/medical needs. Traditional medicine in particular has survived great pressure and condemnation from westernized professionals. Yet both systems continue to be patronized by the people depending on their socio-cultural and economic situations. ... Nigeria[n] [government] has not accorded traditional medicine its primate position in its health care delivery system. Consequently today, traditional medicine is practiced without an enabling legislation, as the National Assembly is yet to pass the Traditional Medicine Council Bill (TMCB) presented to it since 2007." See also Omoleke Ishola, *The "Relevance" of the African Traditional Medicine (Alternative Medicine) to Health Care Delivery System in Nigeria* (2013) 47 *The Journal of Developing Areas* 319.

<sup>12</sup> With the general guidance, support and technical supervision of State Health Ministries, under the aegis of Ministries of Local Government, Local Government Councils shall design and implement strategies to discharge the responsibilities assigned to them under the Constitution, and to meet the health needs of the local community.

of the 1999 Constitution<sup>13</sup> with the support from federal government for formulating overall policy, monitoring and evaluation, and with state governments providing logistical supports – personnel training, financial assistance, planning and operations.

Within the Nigerian healthcare system, some agencies were created for the purpose of providing effective monitoring of health related issues.<sup>14</sup> Among these are the National Agency for Food and Drug Administration and Control (NAFDAC), the National Programme on Immunization (NPI) the Nigerian Institute for Medical Research (NIMR) and the National Action for Prevention and Control of AIDS (NAPCA).

The constitutional provisions of s. 17 of the 1999 Constitution create a national healthcare policy and the provision of healthcare delivery is a concurrent responsibility, divided into three sectors – tertiary, secondary and primary – which remain the functions of the three tiers of government – federal, state and local government. Nigerian healthcare services, in contrast to those of many other countries,<sup>15</sup> are neither free nor subsidised at either tertiary or secondary levels as healthcare institutions demand of patients that they provide a deposit before treatment is given even in cases of emergency.<sup>16</sup> At the primary level there is

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<sup>13</sup> Section 7(2) The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters – (c) the provision and maintenance of health services.

<sup>14</sup> World Health Organization (2007).

<sup>15</sup> Mariana Mota Prado, "Provision of Health Care Services and the Right to Health in Brazil: The long, Winding, and Uncertain Road to Equality", Chapter 12 of C Flood & A Gross eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014) 319, at 320, states: "After 1988, Brazil started to offer free health care to all citizens but nonetheless allowed the continuance of a supplementary private health care system. While all citizens can obtain free health care in the public system at no charge, many elect to use the private system for most (if not all) services. This private system is supplementary (not complementary) to the public health care system; in other words, those who have chosen to have private care can still use the public system."

<sup>16</sup> Obidimma & Obidimma, *Legal and Ethical Issues in the Demand for Payment before Treatment in Nigerian Hospitals* (2015) 38 *Journal of Law, Policy and Globalization* 176. Yusuf O. Ali (SAN), "Negligence and Damages Section of the International Bar Association Conference", *A Doctor's Nightmare: Protection From Medical Malpractice Suits – The Nigerian Perspective* (2<sup>nd</sup> October 2012, Dublin), stated (at p 16) that: "In Nigeria, the

system for free immunisation and treatment of minor injuries, health education, school health, mental health at minor level, and maternal and child health (antenatal, perinatal, and postnatal) care.<sup>17</sup>

The respective roles and responsibilities of the various tiers of government in healthcare delivery have not been defined clearly under the Constitution.<sup>18</sup> This has created a lacuna which results in duplication of healthcare services whereby the separate tiers of government take different initiatives without proper coordination or collaboration<sup>19</sup>, making the healthcare services at all levels cost-inefficient in regard to the use of personnel and facilities.

The federal government has responsibility for tertiary healthcare where specialized health services are rendered by providing for University Teaching Hospitals and Specialist Hospitals where doctors are trained and monitoring of disease outbreak, such as Ebola.<sup>20</sup> The teaching and specialist hospitals are supposed to serve as

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inequitable distribution of health care facilities, inflationary cost of health care services and inadequacy of existing infrastructure are some of the serious and inaccessibility of existing infrastructure are some of the serious challenges to the survival of an average Nigerian. There are the everyday emergencies that have ended in fatality because of the down payment before treatment policy, even in public hospitals.”

<sup>17</sup> Abdulaheem, Olapipo & Amodu, *Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities* (2012) 4 *Journal of Public Health and Epidemiology* 5, at 6-7, the authors state: “The essence of health care to the local government is to make the management of PHC services more effective and closer to the grassroots. However, in view of the level of health awareness, one begins to question the extent to which health care has been taken to the doorstep of the rural people. One of the hindrances to the development of health especially in Nigeria has to do with insufficient number of medical personnel as well as their uneven distribution. ... There has been too much concentration of medical personnel at the urban to the neglect of the rural areas. Another significant problem in the management of PHC is transportation. It has been reported in LGA PHCs that there are not enough vehicles for workers to perform their task especially to the rural areas. Immunization outreach services are inadequately conducted. The maintenance culture of the existing vehicles is poor while PHC vehicles were used for other purposes other than health related activities.”

<sup>18</sup> Lily Nnenna Ozumba, *Multi-sectorial Assessment of Policy Implementation in the Nigerian Socio-political System* (2014) 2 *Journal of Good Governance and Sustainable Development in Africa* 113, at 317, making analysis on health policy, states: “... attempts have been made to improve the functional efficiency of Teaching Hospitals. But it has been contented that it is lack of political will and poor policy making that failed to divide responsibilities effectively between Federal, State and Local governments that resulted in Primary Health Care services lacking staff and funds.”

<sup>19</sup> See the Communiqué of the 2012 Association of Public Health Physicians of Nigeria (APHPN) held at Tinapa Tourist and Business Resort, Calabar, Cross Rivers State, *The National Health Bill – A major factor plaguing the health sector is the lack of constitutional clarity of roles and responsibility of the different tiers of government in health services provision resulting in lack of coordination as all tiers of government get involved in all aspects of the health system.*

<sup>20</sup> Centres for Disease Control and Prevention, *Ebola Virus Disease Outbreak – Nigeria*, (2014) 63(39) *Morbidity and Mortality Weekly Report* 867, at 867, the authors report: “The first known case of Ebola in Nigeria was in a



referral hospitals except in emergency from secondary healthcare facilities but the reverse is the case in most situations as many patients prefer to attend teaching or specialist hospital without referral from the secondary level for fear of inadequate personnel or substandard healthcare facilities at the state hospitals.<sup>21</sup> The state undertakes secondary healthcare, providing General Hospitals and Comprehensive Health Centres for the training of nurses, midwives and community health extension workers. These institutions also serve as referral for the primary healthcare provided by local government through dispensaries and maternity centres. Although it was intended that primary healthcare should be the first level of contact for patients, the reality is that patients bypass this level and resort to the secondary or tertiary level on many occasions.

The delivery of primary healthcare services is weak because of the inadequate resources and facilities afforded by either the federal government or the state governments. These inadequacies have been identified by Health Partners International<sup>22</sup>, a specialist in health systems and management. Noting that

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traveller exposed in Liberia. ... On arrival the afternoon of July 20, he was actually ill and immediately transported to a private hospital where he was noted to have fever, vomiting, and diarrhoea. During hospital admission, the patient was queried about Ebola and said he had no known exposure; he was initially treated for presumed malaria. Based on the patient's failure to respond to malaria treatment and his travel from an Ebola-affected country in the region (Liberia), the treating physicians suspected Ebola. The patient was isolated and tested for Ebola virus infection while local public health authorities were alerted about a suspected case of Ebola. A blood specimen sent to Lagos University Teaching Hospital was confirmed positive for acute Ebola virus infection. The patient died on July 25."

<sup>21</sup> Makanjuola Akande, *Population with ill-health burden; faced with a sick health system*, "142<sup>nd</sup> Inaugural Lecture at University of Ilorin, Kwara State, Nigeria" (13 February 2014), at p 16-17, states: "In a study at UITH (University of Ilorin Teaching Hospital) outpatient department; only 7.1% of the patients were referred from other health facilities. The implication is that 92.9% of the new patients were using a tertiary health facility as first point of contact with the national health system. Other studies have shown that the lack of human and material resources as well as the lack of confidence in the lower levels of care is responsible for this practice. The out-patient departments in Teaching Hospitals in Nigeria are overcrowded and most often with simple ailments that can be treated at the lower levels of care. ... Patients with chronic illness and some acute illness usually need to be followed up after the initial diagnosis and treatment. The most common reason for default was financial challenges faced by patients. Other reasons include; forgetting dates, travels and engagement with other things like work. Default in attending clinics contributes to increase in disease burden and mortality and a source of inefficiency and waste of resources in health facilities."

<sup>22</sup> *Structuring and organisation of health services* ([www.healthpartners-int.co.uk/.../structuring\\_and\\_org\\_of\\_health\\_serv.pdf](http://www.healthpartners-int.co.uk/.../structuring_and_org_of_health_serv.pdf)), at p. 1, states: "Many countries experience a fragmented health system with ineffective links between levels or between primary and secondary health services. Often the health system is centralised and

decentralisation and strengthening of district health systems are common strategies for structurally changing health services in low-income countries, especially in Africa, it observes that:

*“Full decentralisation of responsibility for health services to local authorities has often been seen as an ideal for district health systems – to establish strong local accountability and bring health services closer to the people. Experience across Africa has not been encouraging, however. In Nigeria, ... delivery of primary-level care was fully decentralized to Local Government Authorities (LGAs) more than two decades ago, with hardly any accountability for service delivery to higher levels and weak support and oversight. This appears to have contributed significantly to the dramatic decline in primary healthcare services in Nigeria – and to the difficulty in resurrecting them. Health services are technically complex and local authorities find them very difficult to manage on their own.”<sup>23</sup>*

The standard tests for healthcare delivery are measured in terms of availability, accessibility, acceptability and quality of the services provided. Unfortunately, all

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lower-level managers, staff and the community have little say in how services are provided or run. Referral systems are also poor. This leads to demotivated health workers; inadequate resource allocation at the service point; no responsibility or accountability on the part of frontline health workers and managers – and, invariably, poor health services.”

<sup>23</sup> Health Partners International: *Structuring and organisation of health services* ([www.healthpartners-int.co.uk/structuring\\_and\\_org\\_of\\_health\\_serv.pd...](http://www.healthpartners-int.co.uk/structuring_and_org_of_health_serv.pd...)), at p. 1-2. See also Gupta, Gauri & Khemani, *Decentralized Delivery of Primary Services in Nigeria: Survey Evidence from the States of Lagos and Kogi* (Africa Region Human Development Working Paper Series, 24 September 2003), (at p v): “It is increasingly being recognized that simply allocating greater public resources to basic health services is not enough to ensure that quality services are made available to the vast majority of poor citizens in the developing world. The impact of public spending on actual outcomes in health service delivery depends critically on existing institutions and incentives in the public sector. In recent years, public revenues in Nigeria have increased substantially due to the boom in world oil prices, and some of this windfall is being channelled into increased spending on primary healthcare. Yet, there remains a concern whether the institutions of public accountability in the country will effectively allow these large spending programs to translate into improved services and outcomes. A major channel through which increased public resources are expected to impact basic health and education services in Nigeria is that of spending by local governments that are largely responsible for these services. It is therefore important to delve deeper into the role of local governments and community organizations in basic health service delivery.”

these are lacking in Nigeria and the absence contributes largely to the poor standard of healthcare services provided by the three tiers of government. These observations were expressed in the Communiqué of the 2009 Nigerian National Health Conference (NHC 2009)<sup>24</sup>. The Director-General of Standards Organisation of Nigeria (SON), Joseph Odumodu, in his lecture, titled: "The 21st Century Pharmacy Professional in Healthcare and National Development" on why Nigeria's healthcare delivery system is poor, remarked that:

*"Generally, healthcare services are fragmented, skewed in distribution, limited in coverage and of poor quality."*<sup>25</sup>

This description applies particularly to healthcare delivery at primary level. The underlying cause for the inadequacy of doctors particularly at primary and secondary level is the reluctance of doctors to work at primary level and this could be attributed to the residency training undergoing at tertiary level where they gain more knowledge and improve on their career to promote development that exposed them to competition unlike the primary healthcare that puts limitation to research, training and specialisation.

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<sup>24</sup> Cf *Primary Health Care in Nigeria: 30 Years After Alma-Ata*, at 2: "Despite investments in the health sector, the health system remains weak as evidenced by lack of coordination, fragmentation of services, dearth of resources, including drug and supplies, inadequate and decaying infrastructure, inequity in resource distribution and access to care and very deplorable quality of care. Lack of clarity of roles and responsibilities among the different levels of government has compounded the situation. The MDG funding is seen as a replacement of regular government funding, which should not be the case. Human resource for health remains a challenge. While Nigeria's human resource availability is among the best in Africa, it is still inadequate. Attrition, mal-distribution, non-engagement, skewed mix, especially at PHC level, poor and inequitable remunerations, poor attitude to work and inadequate supervision remain major issues. Primary health care, which is the bedrock of Nigeria's health policy and identified as central to the health care delivery system remains prostrate. The level of government saddled with the responsibility of primary health care services provision (LGA) is the level least committed and with the least capacity."

<sup>25</sup> Vanguard (Nigeria Newspaper, 2 December 2011). Temitayo Olofinlua, *Medical Negligence In Nigeria: When Hospitals Kill* (Radiant Health Magazine, 8 June 2015), the editor (at p 3 of the electronic version) comments: "If America suffers ... degree of medical negligence, even with its more highly developed and sophisticated health care system, then it follows that Nigeria, with its weaker health care infrastructure and under reporting of medical negligence cases, is even worse off. And while there is no incontrovertible data on the actual number of medical negligence cases in Nigerian hospitals, patients and medical practitioners alike acknowledge that number to be high."

Despite some judicial intervention in advancing the right to health through the regional and international instruments,<sup>26</sup> there remain impeding factors, both socioeconomic and political, that inhibit the realisation and enjoyment of the right to health in healthcare delivery system.<sup>27</sup> One obvious challenge confronting the healthcare sector in Nigeria is the brain drain or skill flow of medical personnel due to poor incentives<sup>28</sup> and economic inequalities at both national and international levels. This has created a shortage in the availability of health personnel in meeting the standard of primary healthcare delivery, resulting in poor health outcomes, illness and high levels of mortality.<sup>29</sup> The dearth of medical personnel in public hospitals usually results in overcrowding and in many cases increased medical errors where there is a wide gap of doctor-to-patient ratio.<sup>30</sup>

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<sup>26</sup> *Odafe & Ors v A.G* (2004) AHRLR 205.

<sup>27</sup> C Flood & A Gross, "Context for the Promise and Peril of the Right to Health", *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014) 451, at 466, the authors in assessing the impact of litigation in addressing the right to health and the deficiencies in the healthcare delivery, remark: "Litigation does not play any important role in Nigeria, due to lack of social mobilization, legislation, and constitutional rights, combined with an absence of democratic accountability and political legitimacy."

<sup>28</sup> Obiajulu Nnamuchi, *The right to health in Nigeria* (Centre for Health, Bioethics & Human Rights, 12 December 2007) 1, at 24, states: "Nigeria is a major health-staff-exporting nation, accounting for 347 (recently revised upward to 432) out of a total of 2000 nurses that emigrated out of Africa between April 2000 and March 2001. This figure appears to be underreported as it fails to take account the vast number of nurses who migrate abroad under different pretexts. A recent study found that the number of Nigerian physicians employed in the United States far exceeds that of any other country in Africa. There is no data on the exact number of migrant physicians and other medical professionals but the range is estimated to be several thousands. The efflux has resulted to acute shortages in local health facilities and drastically impacted access. ... Related to brain drain is the problem of geographical distribution of health care professionals. There is a disproportionate concentration of medical professionals in urban areas. While access to medical personnel is easily obtainable in cities, rural dwellers often have to travel considerable distance in order to get treatment. This has significant consequences on the health of inhabitants of rural areas as unavailability of physicians and nurses within close proximity often leads to delaying and postponing visits to health care facilities until the condition becomes unbearable. Transporting the patient on treacherous roads to urban facilities may take several hours and this may mean the difference between life or death."

<sup>29</sup> Fitzhugh Mullan, *The Metrics of the Physician Brain Drain* (2005) 353 N Engl J Med 1810, at 1817, in his analysis, states: "... the brain drain has also weakened the physician workforces of many poor nations and limits the ability of those nations to respond to HIV infection, AIDS, and other pressing needs."

<sup>30</sup> Alexander Chiejina, "Official! One doctor to 6400 patients in Nigeria" (Nigeria Intel, 3 May 2013), the author states: "Official statistics show that there is one doctor to every 6400 patients in Nigeria. This falls far short of the World Health Organisation (WHO) standard of one doctor to every 600 patients and is a grave threat to the physical and mental wellbeing of the country's populace. ... To meet the WHO benchmark, Nigeria needs to have 283,333 doctors, measuring by a 170 million population base. This means that the country needs 283,308 additional doctors at present. One of the causes of the shortage of medical doctors in the country is the massive exodus of medical professionals in search of greener pastures."

The phenomenon of the brain drain has provoked much discussion as to the international recruitment of health workers.<sup>31</sup> Some commentators have defended the migration of health workers as conferring benefits in equal measure on both the source country and the destination country.<sup>32</sup> However, the recruitment exercise has generated criticisms among human rights activists and academics who have advocated the cessation of the activities of the healthcare recruiters on the basis that it constitutes a violation of rights to access healthcare<sup>33</sup>. Some have even gone so far as to contend that this unethical conduct should be treated as an international crime.<sup>34</sup>

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<sup>31</sup> WHO (2009): *A World Health Organization Code of Practice on the International Recruitment of Health Personnel*, at p 3, observes: “The debate about international health worker recruitment and its impact on health systems has been pronounced in recent years. As a consequence of the globalization of health and health services, every country has an interest in the long-term objective of improving health systems in all countries. Towards this end, there is a need for global consultations to move to the next stage by establishing consensus on a WHO code of practice that effectively balances the interest of all countries. Health worker migration and international recruitment also have a particular significance to primary health care, a global public health priority. Primary health care systems in some developing countries are understaffed and extremely vulnerable to out-flow of personnel to urban areas and to other countries. In addition, primary health care systems in some developed countries, particularly in rural/remote areas, are dependent on internationally recruited staff. Consequently, achieving global consensus on a WHO code of practice could be an important factor in supporting improvements in the human resource components of primary health care.” Commonwealth Code of Practice for The International Recruitment of Health Workers (2003), at para 4, observes: “This Code of Practice for the International Recruitment of Health Workers is intended to provide governments with a framework within which international recruitment should take place. The Code is sensitive to the needs of recipient countries and the migratory rights of individual health professionals. The Code does not propose that governments should limit or hinder the freedom of individuals to choose where they wish to live and work. Commonwealth governments may wish to supplement the Code with additional guidance particular to their own national needs and situations.” See also Tulloch, Machingura & Melamed, *Health on the Move: Migration, Well-being and the 2030 Agenda for Sustainable Development* (July 2016) ODI: Swiss Agency for Development and Cooperation SDC 1, at 7.

<sup>32</sup> Fitzhugh Mullan, *The Metrics of the Physician Brain Drain* (2005) 353 N Engl J Med 1810, at 1817, states: “[P]atterns of migration have provided benefits in the form of services to the recipient countries and benefits in the form of remittances to the source country.” Javier S. Hidalgo, *The active recruitment of health workers: a defence* (2013) 39 J Med Ethics 603, at 609, states: “The active recruitment of health workers is generally morally permissible and, even when this recruitment is wrong, most recruiting organisations are excused. The criminal law should aim to only sanction actions that are morally impermissible and culpable – only morally impermissible and culpable actions are the fitting objects of state punishment. So, it is unjust for states to punish the active recruitment of health workers.”

<sup>33</sup> Mills, Schabas, Volmink, Walker, Ford, Katabira, Anema, Joffres, Cahn & Montaner, *Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime?* (2008) 371 J Lancet 685, at 687, remark: “Active recruitment of health workers from African countries is a systematic and widespread problem throughout Africa and a cause of social alarm: the practice should, therefore, be viewed as an international crime.” See further Ferracioli & De Lora, *Medical Brain Drain and the Duty to Stay* (2015) 40 J of Med & Philosophy 601.

<sup>34</sup> *Ibid.*, at 687, states: “Active recruitment is considered unethical under many national policies, leads to negative health outcomes, and undermines the right to health as asserted in the Universal Declaration of Human Rights,

Opponents of this approach focus on the freedom of healthcare workers to migrate<sup>35</sup> and, more generally, to make personal decisions as to where to live and work.<sup>36</sup>

Other factors damaging the efficacy of healthcare in Nigeria include resource limitations on the health budget, corruption in the allocation of medical resources to the detriment of the patients,<sup>37</sup> and the global exploitation of developing nations by drugs companies which seek to carry out research trials in countries with less demanding protection of human subjects regarding informed consent.<sup>38</sup>

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various International Covenants, and numerous declarations and legally binding treaties including the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women.”

<sup>35</sup> Michael Clemens, *Skill Flow: A Fundamental Reconsideration of Skilled-Worker Mobility and Development* (Centre for Global Development 2009, Working paper 180) 1, at p 11, states: “[E]migration from a developing country is an active choice made by a person from a developing country. ... In fact, almost all skilled migrants from developing countries choose to migrate. The fact that some governments plan for or act to influence migration does not mean that migrants are passive or that migration is not a choice. All people’s choices are influenced by government action to some degree, but they make choices nonetheless. ... one thing many skilled workers express with their choice to migrate is a desire for freedom from violence, fear, political repression, uncertainty, and economic insecurity.” Hadas & Lang, *Brain Drain and Brain Gain: Problems, Paradoxes, and Trends in International Skill Flows* states (at p 13-14) in their working paper that: “Skilled migrants are not ‘owned’ by their home countries, and should have the same rights to freedom of movement as professionals in rich countries. This standpoint implies the moral importance of expanding the choices of skilled people and permitting their mobility ‘as long as it does not illegitimately affect the freedom of others’.”

<sup>36</sup> Mills, Schabas, Volmink, Walker, Ford, Katabira, Anema, Joffres, Cahn & Montaner, *Should active recruitment of health workers from sub-Saharan Africa be viewed as a crime?* (2008) 371 J Lancet 685, at 687, state: “We, ... recognise that while there is a right to health for everyone, there are also health-workers’ rights to consider. Health workers should have freedom of movement and choice of where they live and work, just as any workers should. To encourage the retention of health workers, government and policy makers need to use incentives and to address the reasons for migration: low salaries, inadequate resources, long hours and heavy workloads, a threat of infections and violence, and lack of career development.”

<sup>37</sup> Obansa & Akingbade, *Health Care Financing in Nigeria: Prospects and Challenges* (2013) 4 Mediterranean Journal of Social Sciences 221, at 222, remark: “The Nigerian health system is in comatose, few hospitals with few drugs, inadequate and substandard technology and lack of infrastructural support, including electricity, water and diagnostic laboratories resulting in misdiagnosis. Medical record keeping is rudimentary and diseases surveillance is very poor. Delivery of health care becomes a personal affair and dependent on ability to pay for basic laboratory and physician services.” Kwanga, Kirfi & Balarabe, *Social Security Reform and Service Delivery: A Study of NHIS (client’s – Service Providers’ Relationship) in Kebbi State, Nigeria* (2013) 2 International Journal of Humanities and Social Science Invention 86, at 87, observe: “[I]n Nigeria like most African countries, the provision of quality, accessible and affordable healthcare remains a serious problem. This is because the health sector is facing gross shortage of personnel, inadequate and outdated medical equipment, poor funding, police inconsistency and corruption.”

<sup>38</sup> *Abdullahi v Pfizer* (2009) 562 F. 3d 163. Adebola Olufowobi, *Protecting the Rights of Children as Human Subjects in Developing Countries: Revisiting Informed Consent* (2014) 544 Law School Student Scholarship 1, at 24-25, analyses that: “In many developing countries, like Nigeria for example, it is customary in some communities for community leaders to give consent on behalf of its members. In some patriarchal cultures, females are prohibited from making personal important decisions for themselves or on behalf of their children. Nigeria as a country is a multi-cultural, multi-ethnic, and multi-religious nation and the perceptions on health issues are strongly influenced

The misallocation of resources by the healthcare administrators<sup>39</sup> has resulted in inadequate funds at the point of service and has created a negative impact on the consumers.<sup>40</sup> The most obvious examples of corruption and mismanagement in the

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by these factors as well as the belief in the extended family system. Northern Nigeria has a strong centrally-controlled feudal system that has strong influence on the decision to undertake treatment, which sometimes could be detrimental to the patient. In such culture, 'community consent clashes with the Declaration's policy that individuals personally volunteer for the experimental procedure'. As David Carr noted, if a country does not codify the community consent within its laws, researchers would be left with no guidance to deal with communities that traditionally allow community consent. In Pfizer's Trovan case however, conducting an experimental research along with providing charitable medical care to sick people may lead to misconception by the patients who may not necessarily volunteer for the research but for the treatment. Under such circumstances, where medical treatment is being rendered by charitable organizations, it is easy for a subject to mistake the experimental research for treatment and thereby 'disposing of the need for researchers to obtain consent'.<sup>39</sup> Stevina Evuleocha, *The Global Market in Human Experimentation: Pfizer and the Meningitis Experiment in Nigeria* (2012) 2(6) *Interdisciplinary Journal of Research in Business* 46, at 49, identifies a discrepancy between the theoretical and practical standard test on informed consent in Nuremberg Code (WHO). The author (at 49), states: "Many of the parents of the children participating in the Pfizer research insisted that they did not understand their children were participating in experimental research. One wonders if Pfizer's doctors obtained consent from the children participating in the research without duly informing parents of the nature of the research. Whether the ethical review board in charge of supervision failed in its capacity to inform Pfizer's doctors about local laws regarding competency of minors or whether local laws defining competency of minors did not exist at the time, the charge against Pfizer's doctors failed to recognize the need for supplemental consent serves to illustrate the weakness in the Declaration's practical implementation. The Declaration adequately addresses theoretical issues of competency and understanding of the research subject, but fails in its practical application." Adebayo Adejumo, "Ethical Issues in Scientific Research", Chapter 3 of Olayiwola Erinsho ed, *Ethics for Public Health Research in Africa* (Social Science Academy of Nigeria, 2008) 24, at 27-28, states: "It is vital for researchers to adhere to ethical standards in their relationship with the less advantaged members of the society. This becomes imperative due to the growing appreciation of the rights of patients and the global request for the protection of human subjects who are included in investigative procedures. Without these, the gains that are already recorded in the growth of science would be reversed. Research activities in whichever discipline and professional practice that do not adhere to ethical standards amount to mere exploitation of the less-advantaged fellow human beings as was the case in the days of the Tuskegee syphilis study."

<sup>39</sup> Obiajulu Nnamuchi, *Kleptocracy And Its Many Faces: The Challenges Of Justiciability Of The Right To Health Care In Nigeria* (2008) 52 (1) *J of African L* 1, at 10. The author analyses the negative impact of corruption on realization of the right to healthcare, he notes: "In addressing the centrality of good governance to the effective implementation of human rights, the UN Committee on Economic, Social and Cultural Right (Committee on ESCR) stressed that to be successful, a national health strategy and plan of action should be anchored on the principles *inter alia* of 'accountability' and 'transparency'. Conversely, bad governance, in terms of accountability and transparency void, as quite often typified by corruption and economic mismanagement can have a devastating impact on human rights particularly socio-economic rights, for in contradiction to civil and political rights, the realization of socio-economic rights is wholly dependent on availability, proper allocation and efficient utilization of resources, and misuse often result to severe hardship and deprivation for those on the receiving end. Given its furtive ability to stunt economic growth and thus availability of resources, corruption or absence thereof is a critical determinant of the extent to which socio-economic rights and general development goals are realizable within a particular jurisdiction. This probably explains why nearly every malaise in Nigeria finds a ready culprit in corruption. While this is somewhat exaggerated and scarcely sustainable, it is the key to understanding the genealogy and intractable nature of current challenges facing the country, particularly within the health sector."

<sup>40</sup> Kamorudeen & Bidemi, *Corruption in the Nigerian Public Health Care Delivery System* (2012) 2 *Sokoto J of the Social Sciences* 98, at 106, states: "Corruption in the health sector ... has a direct negative effect on access and quality of patient care. As resources are drained from health budgets through embezzlement and procurement fraud, less funding is available to pay salaries and fund operations and maintenance, leading to de-motivated staff, lower quality of care, and reduced service availability and use ... The poor are disproportionately affected by corruption in

healthcare sector are the lack of essential drugs as a result of diversion to private use or to the private market for sale at higher prices, and the practice by foreign healthcare providers of providing "incentives" to Nigerian doctors to refer their patients to these providers.<sup>41</sup>

The menace of corruption in Nigeria has to a great extent inhibited the effective implementation of healthcare delivery ranging from primary to tertiary level, with corruption remaining endemic in both the private and public life of individuals.<sup>42</sup>

The allegation of corrupt practices in the healthcare administration could be a matter for litigation before the court for a violation of rights to access healthcare delivery against both the state<sup>43</sup> and private parties whose conduct is found wanting for the enjoyment of the right.<sup>44</sup>

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the health sector, as they are less able to afford small bribes for health services that are supposed to be free, or to pay for private alternatives, where corruption has depleted public health services." Similar concerns have been experience in Ghana. Pius Agbenorku, *Corruption in Ghanaian healthcare system: the consequences* (2012) 10 Journal of Medicine and Medical Sciences 622, at 623, states: "Ghana's public health care system has been faced with some issues of corruption, in its 2006 Global Corruption report, Transparency International 'has identified the health sector of Ghana as a corruption prone area with evidence of bribery and fraud across the breadth of medical services. This is said to have emanated from petty thievery and extortion, to massive distortions of health policy and funding, fed by payoffs to officials in the sector'."

<sup>41</sup> Mustapha Danesi, *Policy Dialogue: Nigeria Operating 19th Century Health System* (Financial Nigeria Magazine, and Nigeria Development and Finance Forum), stated: "Many doctors in Nigeria need re-training to upgrade their practice from stage 1 to the current 21<sup>st</sup> century stage 4 healthcare system. Many doctors should be taught to know when to refer patients to other experts and where the experts are in Nigeria; some doctors refer directly to India instead of Nigerian experts partly because they do not know them and partly they are given generous incentives to do so by way of commissions from Indian hospitals."

[www.nigeriadevelopmentandfinanceforum.org/PolicyDialogue/Dialogue](http://www.nigeriadevelopmentandfinanceforum.org/PolicyDialogue/Dialogue).

<sup>42</sup> Mojeed Alabi, *Politics And Law: Anatomy of the Siamese Twins*, "153<sup>rd</sup> Inaugural Lecture, University of Ilorin, Kwara State, Nigeria" (13 November 2014), at p 20-21, examined the core and oversight functions of legislatures, states: "One area in which the legislatures have been found deficient in performance is in tackling the scourge of corruption and maladministration. But the legislature alone cannot answer for such an endemic problem. My continent-wide survey of the legal regimes of anti-corruption shows that while many African countries have legal provisions in national constitutions, criminal laws, penal codes, civil service regulations and ethical codes of public service, backed by international treaties, conventions, protocols and declarations, as part of the larger reform agenda targeted at innovation and modernisation of the African public sector for performance, results and optimal service delivery, the leadership lacks sufficient political will to tackle the menace of corruption. Thus, reform efforts are threatened by implementation challenges that have continued to retard, rather than enhance, the progress towards improved public service ethics and anti-corruption. The judiciary and the entire legal system have been found equally culpable. In fact, rather than serve as an effective instrument of anti-corruption, the legal process has been manipulated to frustrate the crusade."

<sup>43</sup> In *SERAP v The Federal Republic of Nigeria and Universal Basic Education Commission* (30 November 2010) ECOWAS Community Court of Justice, the plaintiff alleged that a high level of corruption and theft of funds intended for primary education in Nigeria amounted to a denial of the right to a qualitative, free and compulsory primary education for Nigerian. The court held that there must be a clear linkage between the acts of corruption and a



The deplorable condition of the healthcare services has resulted in the phenomenon of patients who can afford the costs going overseas for medical attention or further treatment on account of wrong diagnosis.<sup>45</sup> Those who cannot afford it solicit for funds from the public through the media and other means, sometimes when they are at the point of death.<sup>46</sup> The practice hitherto was that public office holders frequently sought medical treatment abroad without exploring the healthcare facilities at home.<sup>47</sup>

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denial of the right to education. The Court (at para 20), stated: “It is a serious indictment on authorities of the [defendant] which calls for strict proof, being a criminal matter. In the absence of such proof, the Court will reject any suggestion of high level corruption in the educational sector which has resulted in a denial of the right to education.”

<sup>44</sup> Ebenezer Durojaye, *The approaches of the African Commission to the right to health under the African Charter* (2013) 17 Law, Democracy & Development 393, at 403, states: “The obligation to protect the right to health implies that government must take necessary steps to ensure that the actions of a third party do not interfere with the enjoyment of the right. Thus, failure of a state to address endemic corrupt practices in the health sector, particularly among health care providers, will result in a breach of the obligations to realise the right to health.”

<sup>45</sup> Punch (Nigerian Newspaper), *Medical tourism: Healing Nigeria's health sector* (21 April 2014), reported that: “Health challenges that take Nigerians abroad include kidney, cancer and cardiovascular or heart diseases. The late rights activist, Gani Fawehinmi, who died of cancer a few years ago, bemoaned how his ailment was wrongly diagnosed as pneumonia in Lagos hospitals, only to be belatedly, but properly investigated in United Kingdom.”

<sup>46</sup> See *Medical Visits To India Gulp N30 Billion*: <http://pmnewsnigeria.com/2011/08/01/medical-visits-to-india-gulp-n30-billion/>. A report by the International Medical Travel Journal claimed that at least 3,000 Nigerians travel each month for medical treatment in India, spending close to \$200 million (N30 billion) yearly. This figure was attributed to Nigerian former Minister of Health, Prof. Babatunde Oshotimehin, who blamed the shambolic healthcare system and a very expensive local care. According to Oshotimehin, thousands have died due to complications arising from far distance travel after life saving surgery. Serious medical conditions such as heart disease have led to many Nigerian going abroad for urgent surgery. Many of these are not really fit to travel there and back by normal air. Nigeria healthcare system has degenerated to the extent that many patients no longer have confidence in the system. The report however disclosed that India doctors do not have answers to all Nigerian healthcare problems, as about 1000 cases are mis-diagnosed yearly. These range from emergency or critical life saving operations to routine care. Few use medical evacuation services. The new Executive Director of the United Nations Population Fund (UNPFA), Oshotimehin said, “the state of healthcare in Nigeria, has forced many patients to go abroad for all manner of treatment that could be confidently treated and handled in Nigeria. The country has to make concerted efforts to upgrade her healthcare facilities to the standard that would attract patronage from patients outside Nigeria, or stop Nigerian travelling overseas. Nigerian medical professionals are leaving the country for greener pastures due to lack of infrastructure. Most equipment in our hospitals are either broken down or obsolete. Where you see good ones, they are not in use because people that are supposed to use them are not properly trained. This clearly demonstrates why Nigerians will continue to seek medical care elsewhere unless something urgent is done to rebuild the national health system with a view to returning the patients confidence.”

<sup>47</sup> John Nwofia, *Recipe for surviving the pangs of medical tourism in Nigeria* (Nigerian Health Journal, 28 February 2011), states: “... Medical tourism has been part of our system for years. Then it was only the rich and our leaders that participated. We all remember the case of the President Babangida and his case of Raiculopathy. He was flown to Paris to have the surgery done. This was something that could have been done at Lagos University Teaching Hospital (LUTH) or any hospital by a neuro or orthopaedic spine surgeon. Then it was the government that spent billions. Now, add to that the billions now spent by private Nigerians to travel abroad for treatment they can get at home.” Usha Anenga, *Doctors in Nigeria should be allowed to advertise* (7 September 2014, Nigerian Medical Students' Association), writes: “Nelson Mandela, the former President of South Africa in all his majesty lay in

The phenomenon of patients travelling abroad for healthcare intervention and related matters have been described as "medical tourism".<sup>48</sup> The traffic goes both ways. Patients from the United States of America and Western Europe go to destinations such as the Czech Republic, India and Thailand in order to access cheaper or more expeditious healthcare than is available at home. Patients from developing countries go to these destinations and also to Britain and America in order to access healthcare that is of better quality than is available at home, protect their confidentiality<sup>49</sup> and benefit from more advanced medical technology.<sup>50</sup> Patients who engage in medical tourism are willing to take the risk of venturing into the unknown, to some extent, as regards the quality of their treatment and their practical prospects of obtaining compensation in the event of negligence in the delivery of healthcare abroad.<sup>51</sup>

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intensive care for several months, entrusting his life in the hands of home-trained physicians and died with pride in his country. It's the other way round in Nigeria." [www.ynaija.com/opinion-its-high-time-nigerian-doctors-started-advertising/](http://www.ynaija.com/opinion-its-high-time-nigerian-doctors-started-advertising/)

<sup>48</sup> The government is making a positive effort to curb the efflux of medical tourism in making Nigeria attractive to medical tourists by researching the area of its specialisation that can be managed effectively including medical, surgical and dental services on the available modern medical equipment for diagnosis and treatment (Leke Pitan, *Medical Tourism In Nigeria: Prospect and Challenges* (1999-2003) Lagos State Health Service Commission, Nigeria 1 at p 2). The primary objectives aim at promoting the quality of healthcare delivery at all levels of government and delivering the standard of care to patients during the course of professional practice. It is argued that the profits that are being realised under medical tourism will increase the national revenue and personal income of the local residents, giving the government an opportunity to improve and expand the health facilities likewise the quality of healthcare delivery to the citizenry. Cf Bookman MZ & Bookman KR, *Medical Tourism In Developing Countries* (First ed, Palgrave Macmillan 2007), at 179; Mattoo & Rathindran, *How Health Insurance Inhibits Trade in Health Care* (2006) 25 *Health Affairs* 358, at 359; Chinai & Goswami, *Medical visas mark growth of India medical tourism* (2007) 85 *Bull World Health Organ* 164, at 165.

<sup>49</sup> Daily Trust (Nigerian Newspaper), *Nigeria: How Nigerians Spend Billions on Medical Tourism* (5 January 2013), the editor explains, investigation shows that: "[C]onfidentiality is a major reason many high-profile Nigerians would rather be treated abroad for even minor ailments than staying in Nigeria and have the public know their ailments. The elite will always go out, no matter how many hospitals you have here. It is not a Nigerian thing. It is a worldwide thing."

<sup>50</sup> In *Mathew Chepkwony & Anor v Paul Kemei Kiprono* [2007] eKLR, the High Court of Kenya examined whether the court had jurisdiction to order custody of a minor in favour of a party who is outside the jurisdiction. Ibrahim J noted: "For instance if a minor needs specialized treatment abroad and which is not available in the country, it would be in the best interest of the child to receive such medical treatment. The issue of legal custody cannot override the life and limb of a minor."

<sup>51</sup> Medical tourists are confronted with legal hurdles, including who to sue with regard to remedies that are available in a claim for damages in the event of an adverse medical outcomes arising from negligence. The courts in this situation are required to examine the issue of jurisdiction and provisions of the legislation in reference to tort liability of the country in question to decide liability. However, the EU Directive affirms responsibility of legislation in

Following these inadequacies, including the incessant strikes of healthcare professionals, the private sector has witnessed high patronage. Although the healthcare facilities in the private sectors are better equipped than those of the public sector, more easily accessible.

As a result, the government has taken some proactive measures in improving access to healthcare through the alleviation of adverse health outcomes on the right to healthcare services which is a component of a right to health. This development resulted to the establishment by legislation the mechanisms including National Primary Health Care Development Agency (PHC)<sup>52</sup>, National Health Insurance Scheme (NHIS)<sup>53</sup> and National Health Act 2014 through which to achieve the national objectives on the right to health in conformity with the international frameworks on the implementation of the health policy.

This is evident in the declaration by the WHO that Nigeria is free of Ebola outbreak which was brought to Nigeria in July, 2014 through an infected Liberian traveller, named Patrick Sawyer. The success for the containment of the outbreak was recorded on a well-designed plan with an effective public administration coordinated by federal and state governments in providing financial, material and human resources for the treatment of the infected persons and monitoring of the

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respect of safety and liability to member states where the treatment was carried out. See Directive 2011/24/EU of the European Parliament and of the Council – on the application of patients’ rights in cross-border healthcare. Chapter II Article 4(2)(c), states: “[T]here are transparent complaints procedures and mechanisms in place for patients, in order for them to seek remedies in accordance with the legislation of the Member State of treatment if they suffer harm arising from healthcare they receive.” In many situations, patients are not informed of the risks involved in the treatment and may be encouraged in some cases to sign a disclaimer, although subject to the provisions of the legislation on fairness, waiving their rights before receiving treatment. See generally Scott J Burnham, *Are You Free to Contract Away Your Right to Bring a Negligence Claim?* (2014) 89 Chicago-Kent L. Rev 379; Rebecca Bennie, *Medical Tourism: A Look at How Medical Outsourcing Can Reshape Health Care* (2014) 49 Texas International Law Journal 358, Nathan Cortez, *Recalibrating the Legal Risks of Cross-Border Health Care* (2010) 10 Yale Journal of Health Policy, Law, and Ethics 1.

<sup>52</sup> 1992. Its corporate goals include: Control preventable diseases; Improve access to basic health services; Improve quality of care; Strengthen institutions; Develop a high-performing and empowered health workforce, Strengthen partnerships, and Engage communities.

<sup>53</sup> 2004.

secondary contacts who may have had direct or indirect contact with Ebola patients or with the index patient who brought the disease to Nigeria.<sup>54</sup>

#### *Attempted Reform: The National Health Insurance Scheme (NHIS) Act 2004*

Against this backdrop, the government, in an attempt to reform the healthcare sector for effective delivery and to provide universal healthcare in the form of social health insurance, introduced the National Health Insurance Scheme (NHIS) Act, 2004 which also indemnified healthcare providers for medical malpractice insurance.<sup>55</sup> Health insurance is a system of advance financing of health expenditure through contributions and spreading the risks of incurring health cost over a group of individual and households as social or private health insurance. Prior to this, there had been no health insurance scheme in Nigeria. Individuals shouldered the burden of payment for treatment without obligation from the government or employer to cushion the burden. This type of payment is referred to as "out of pocket" made at service delivery point. The consequences denied many people equitable access to quality healthcare facilities for treatment.<sup>56</sup>

The aims of the National Health Insurance Scheme (NHIS) Act 2004 are to eliminate the "out of pocket" option, subsidize the cost on individuals and improve

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<sup>54</sup> Fasina, Shittu, Lazarus, Tomori, Simonsen, Vibound & Chowell, *Transmission Dynamics and Control of Ebola Virus Disease Outbreak in Nigeria, July to September 2014* (2014) 19 *Eurosurveillance* 1, at 5, state: "We have analysed epidemiology data of what appears to be a limited outbreak of EVD in Nigeria based on data available as of 1 October 2014, with no new EVD cases reported since 5 September 2014. The swift control of the outbreak was likely facilitated by the early detection of the Index entering Nigeria from a country where disease is widespread, in combination with intense contact tracing efforts of all contacts of this Index case and the subsequent isolation of infected secondary cases. In contrast, the initial outbreak in Guinea remained undetected for several weeks. This detection delay facilitated the transnational spread of the virus to Sierra Leone and Liberia, while difficulties and at times inability to track and contain infectious individuals compounded the situation and resulted in an as yet uncontrolled epidemic in these countries."

<sup>55</sup> *National Health Insurance Scheme: Operational Guidelines* (Revised October, 2012), at 2.19.3, provides: "Professional indemnity insurance cover is taken by health care facilities against the risk of professional negligence which may arise in the course of the execution of their professional duties, in which a patient believes he/she has suffered injury or injuries and proceeds to a court of law to seek redress, as a result of which compensation is awarded to the patient."

<sup>56</sup> Onwujekwe, Hanson & Uzochukwu, *Examining Inequities in Incidence of Catastrophic Health Expenditures on Different Healthcare Services and Health Facilities in Nigeria* (2012) 7(7) *PLoS One* 1, at 4, remark, "Poverty is high in Nigeria, with 70% of the population living below the \$1 per day poverty line. People paid mostly through out-of-pocket expenditure, with almost no health insurance, or other pre-payment or assured reimbursement payment mechanisms."

the standard of healthcare delivery for insured persons and their dependants. The scheme also requires healthcare professionals to be registered for professional indemnity cover from any licensed insurance company.

This scheme covers two sectors. First, the formal sector, which includes public and private sector organizations employing 10 or more persons, while the second, the informal sector, comprises the self-employed in both urban and rural areas, and the vulnerable groups – children under five years, disabled and prison inmates.

Its implementation requires participants to seek registration with a Health Maintenance Organization (HMO). The organization is accredited by the NHIS and mandated to provide complaint boxes at provider facilities.<sup>57</sup> It plays a middle role between healthcare providers and insured participants and in turn, pays premium to the scheme. HMO is defined under the scheme as:

*“an organization registered under section 19 of this Act and includes institution, body corporate or a provident association registered by the Council<sup>58</sup> to utilize its administration to provide healthcare services through health centres approved by the Council.<sup>59</sup>”*

The employer pays 10% of the employee’s basic salary while the employee contributes 5% of the basic salary. This policy caters for a couple and four children under the age of 18 years. The HMO links the insured participants with the

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<sup>57</sup> *National Health Insurance Scheme: Operational Guidelines* (Revised October, 2012), at 2.14.16.

<sup>58</sup> “Council” is defined by the NHIS Act to mean the Governing Council established under section 2 of the Act for the scheme. See *National Health Insurance Scheme Act, 2004 Cap 42* (Nigeria).

<sup>59</sup> See *National Health Insurance Scheme Act 2004*. Its functions, include: (i) the collection of contributions from registered employers and employees; (ii) the collection of contributions from voluntary contributors; (iii) payment of capitation to primary providers and fee-for-fee service, per diem, case payment to secondary and tertiary providers; (iv) rendering to the scheme monthly returns on its activities within 30 days of the following month; (v) contracting with healthcare providers accredited by the Scheme for the purposes of rendering healthcare services; (vi) ensuring that contributions are kept in the Scheme’s accredited banks; (vii) establishing a quality assurance system for the provision of quality healthcare providers; (viii) rendering accounts to the NHIS as required; (ix) marketing in accordance to NHIS *Guidelines*; and (x) carrying out such functions as contained in the *NHIS Act* and the *Guidelines*.

healthcare provider of their choice within their locality, although the insured participants may decide to change the healthcare provider where the insured participants are not satisfied with the services rendered.

The insured participants or their dependants report at the healthcare provider's hospital whenever there is any complaint on health matters and they are treated without having to pay additional money other than the premium that had been paid to the HMO.

There is no doubt that NHIS to some extent enables a great number of people who would not have benefited from the cost of health services to have access to the same quality of health services as anybody else upon registration with the HMO by paying a required premium. It offers the insured participants a variety of choice and autonomy on healthcare providers. But it has some challenges. Under the 2004 Act, participation in the Scheme is not made compulsory.<sup>60</sup> The requirement of 10 or more employees fails to determine the financial viability of private organisations, many of the hospitals are not fully equipped with medical facilities and the HMO has not covered all the states of the Federation.

It could be argued that, if the NHIS is administered effectively, it would have been a better ground for a good healthcare system to every Nigerian. At present, the NHIS has failed to achieve its desired objectives.<sup>61</sup>

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<sup>60</sup> Section 16 of NHIS Act, 2004 provides that an employer who has a minimum of 10 employees may, with every person in his employment, pay contributions under the Scheme, at such rate and in such manner as may be determined, from time to time, by the Council.

<sup>61</sup> Menzibeya Welcome Osain. *The Nigerian Healthcare System: Need for Integrating Adequate Medical Intelligence and Surveillance Systems* (2011) 3(4) *Journal of Pharmacy BioAllied Sciences* 470, at 475, states, “[i]n spite of the various reforms to increase the provision of health to the Nigerian people, health access is only 43.3%. The inadequacy of the healthcare delivery system in Nigeria could be attributed to the peculiar demographics of the Nigerian populace. About 55% of the population lives in the rural areas and only 45% live in the urban areas. About 70% of drugs dispensed are substandard. Hence, the ineffectiveness of the NHIS had recently been attributed to the fact that the scheme represents only 40% of the entire population, and 52-60% are employed in the informal sector. Over half of the population live below the poverty line, on less than \$1 a day and so cannot afford the high cost of healthcare.”

Nigeria's overall health system performance was ranked 187th of the 191 member States by the World Health Organization (WHO) in its estimate for year 1997<sup>62</sup> and ranked under Low Human Development at 158 out of 177 countries in the UN Human Development Index.<sup>63</sup> This very weak position is attributable in large part to the poor performance of Primary Health Care (PHC) which forms the basis of national healthcare due to underfunding, mismanagement and lack of capacity at the Local Government level. This is acknowledged in a paper presented by Olaniyan & Lawanson at the 2010 Centre for the Study of African Economies (CSAE) Conference held at St. Catherine College, Oxford, March, 2010, titled: "Health Expenditure and Health Status in Northern and Southern Nigeria: A Comparative Analysis Using National Health Accounts (NHA) Framework.

*“[t]he effort of the Nigeria’s healthcare system to widen health services of satisfactory quality to the vast majority of the citizens is increasingly facing various threats. These include lack of access to quality healthcare by the poor, severe budgetary constraints, uneven distribution of resources among the urban and rural areas, as well as across the geographical regions of the country, inequitable financial system resulting in increasing dependency of out-of-pocket spending. The country’s disease burden is dominated by preventable diseases which has aggravated high poverty level. Federal Ministry of Health (2006) revealed that about 72% of death in Nigeria are due to*

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<sup>62</sup> The World Health Report 2000, *Health Systems – Improving Performance* (World Health Organization 2000) 1, at p 154. Michael Reid, *Nigeria still searching for right formula* (2008) 86 Bulletin of the World Health Organization 663, at 663-664, remarks that despite several attempts at reform over the past 30 years, Nigeria still lacks a clear and coordinated approach to primary health care, he states: “*The world health report 2000* ranked Nigeria 187 out of 191 countries for health service performance, a situation that has not changed much since then, according to Asuzu, who cites several statistics to highlight the inadequacies in Nigeria’s PHC system. Annual budget allocation to health have been persistently below 5% except for the years 1998-1999 and 2002-2003 when they were at or just about this level.”

<sup>63</sup> UN Human Development Report 2007/2008, at p 231.

*communicable diseases. Infant mortality rate in 2008 was 75 deaths per 1,000 live births while the overall under-five mortality rate for the same period is 157 deaths per 1,000 births (NDHS, 2008).’’<sup>64</sup>*

### *Contemporary National Health Policy Goals*

The federal government took further steps to improve health services initiated the vision of becoming one of the 20 leading economies of the world by the year 2020.<sup>65</sup> To realize this vision, it must be closely tied to the development of its human capital through the health sector but its health indicators at moment have remained below national targets and internationally-set benchmarks including the Millennium Development Goals (MDGs)<sup>66</sup> as it concerned health related matters,<sup>67</sup> which have recorded very slow progress over the years.<sup>68</sup>

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<sup>64</sup> Olaniyan & Lawanson, *Health Expenditure and Health Status in Northern and Southern Nigeria: A Comparative Analysis Using National Health Accounts (NHA) Framework* (2010 CSAE Conference held at St Catherine College, University of Oxford, UK) 1, at p 2.

<sup>65</sup> National Strategic Health Development Plan (2010-2015) 1, at 18, states, “To reduce the morbidity and mortality rates due to communicable disease to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of Nigerian.”

<sup>66</sup> United Nations Millennium Declaration (2000): Eight goals have been set to achieve by the year 2015. The goals are: eradicating extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality rates, improving maternal health, combating HIV/AIDS, malaria, and other diseases, ensuring environmental sustainability, and developing a global partnership for development.

<sup>67</sup> Albert Akume, *MDG’s: Isolating and Understanding its Health Component (4, 5 & 6) for Successful Action and Sustainability in Nigeria* (2014) 5(6) *Mediterranean Journal of Social Sciences* 441, at 449. The author examined the Nigeria’s performance in meeting the MDG’s health targets, concluded: “In assessing the performance of MDGs in Nigeria, some are of the view that some valuable progress has been made even though absolute success has not been recorded in all areas of the health components. On the contrarily, some are of the view that MDGs have performed below the expectations of Nigerian for which more effort must be intensified to attain or 2015 is not a Nigerian thing. ... Inferring from this mixed opinions, it is essential that the planning of strategies and capacity building for the successful implementation of MDG’s health goals (4, 5 & 6) for the remaining year should be non-negotiable. In which case capacity building should focus on further: *development of an organization’s core skills and capabilities, such as leadership, management, finance and fund-raising programs and sustainability. It is the process of assisting an individual or groups to identify and address issues and gain the insights, knowledge and experience needed to solve problems and implement change. Capacity building is facilitated through the provision of technical support activities, including coaching, training, specific technical assistance and resource network.*”

<sup>68</sup> Salil Shetty (Amnesty International’s Secretary General), *Millennium Development Goals Are Failing World’s Poorest People* (Amnesty International, 16 September 2010), the author attributed the failure to government insensitivity and abusing of human rights, remarks: “‘*Unless world leaders agree to take urgent steps to uphold the human rights of people living in poverty, the poorest and most disadvantaged people around the world will continue to be left out of the MDGs. But language alone is not enough, people must be able to hold governments accountable*



To improve this, the federal government implemented the Health Sector Reform Programme (HSRP) from 2004-2007, which addressed seven strategic thrusts on government's stewardship role: management of the national health system; the burden of disease; mobilization and utilization of health resources; health service delivery; consumer awareness and community involvement; partnership, collaboration and coordination. The HSRP recorded a number of policy and legislative initiatives which include a National Health Policy review, a National Health Bill and strengthening the National Health Insurance Scheme. In addition, efforts were directed at strengthening disease programmes and improving the quality of care in tertiary health facilities. Despite these initiatives, many of the underlying weaknesses and constraints of the health sector persist.<sup>69</sup>

In consequence of this, the federal government launched the National Strategic Health Development Plan Framework (2009-2015) in July 2009 which is to be developed in accordance with national health policies and legislation, and international declarations and goals to which Nigeria is a signatory, namely, MDGs, the Ouagadougou Declaration on Primary Health Care (PHC) and the Paris Declaration on Aid Effectiveness.

*“As a prelude to the development of the NSHDP, a generic*

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*when they fail to uphold human rights. They should be able to challenge corruption or neglect through courts and regulatory bodies to ensure governments actually fulfil their obligations’.* An estimated 70% of those living in poverty are women. Yet MDG efforts in many countries fail to address the wide-spread discrimination women face in accessing food, water, sanitation and housing, while discriminatory policies, laws and practices that underpin gender-based violence and undermine progress on all the MDGs, have been left to fester. Many states are carrying out mass forced evictions that drive slum dwellers even deeper into poverty and violate their rights to housing. For example, in just one city in Nigeria over 200,000 people are currently facing eviction because the authorities plan to demolish more than 40 informal settlements in Port-Harcourt's waterfront area. Thousands will lose their livelihoods as well as their homes if the demolitions go ahead.” [www.blog.amnestyusa.org/.../millennium-development-goals-are-failing-world...](http://www.blog.amnestyusa.org/.../millennium-development-goals-are-failing-world...)

<sup>69</sup> See generally, Aisha Ghaus-Pasha, *Governance for the Millennium Development Goals: Core Issues and Good Practices* (7<sup>th</sup> Global Forum on Reinventing Government Building Trust in Government, 26-29 June 2007, Vienna, Austria); David Satterthwaite (ed), *The Millennium Development Goals and Local Processes: Hitting the target or missing the point?* (International Institute for Environment and Development, 2003).

*Framework has been developed to serve as a guide to federal, states and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerian. It is expected therefore, that in using this Framework, the Federal, States and LGAs would respectively develop their respective coasted plans through participatory approaches to reflect their context and prevailing issues. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage within the planned period of 2009-2015.*”<sup>70</sup>

The objective of the Framework, National Strategic Health Development Plan (NSHDP) is delivery of quality, efficient and sustainable health care for all Nigerians and the harmonisation of federal, states’ and local governments’ health plans, to serve as the basis for national ownership, resource mobilization/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, *etc.* The framework is based on four cardinal principles – one health policy, one national plan, one budget, and one monitoring and evaluation for all levels of government. It also provides the

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<sup>70</sup> The National Strategic Health Development Plan Framework (2009-2015): Health Sector Development Team 1, at 11.

template for concretizing the health sector development component of the 7-point Agenda, Vision 2020 and a platform for achieving the MDGs.

Based on a multidimensional assessment of the health sector, the Framework also identifies eight priority areas for improving the national health systems with specific goals and strategic objectives – leadership and governance for health; health service delivery; human resources for health; health financing; health information systems; community ownership and participation; partnerships for health development; and research for health.

For each of the priority areas, the framework details the context, goals, strategic objectives, and recommended evidenced-based and cost effective interventions required to deliver improved performance of the health system and health outcomes for Nigeria.

## **Chapter Three**

### **The Right to Health: International Human Rights and Constitutional Perspectives**

#### *Introduction*

In this Chapter, I seek to set out, in broad terms, the manner in which the right to health is recognised and protected in international human rights instruments, at global and regional levels, and in national constitutions. What emerges is a picture

of gradual strengthening of the protection of the right to health, moving from the level of a pious platitude to actual enforcement through the, admittedly weak, international sanctions and the somewhat more effective, though still rarely invoked, sanctions of court decrees under the authority of national constitutions.

It is important that the public law dimension be acknowledged, but equally it is important at the outset that the limitations of this dimension of the law in Nigeria should be recognised. It is not a practical proposition to suggest to the victim of medical negligence, resulting in injury, that he or she should engage in the expensive and speculative process of taking proceedings before international human rights bodies under international law jurisprudence. Victims of medical negligence are thus faced with a dilemma: to launch proceedings for tort, where there is a real risk that the court will regard the deficiencies in the Nigerian healthcare systems as raising series of a political and social character falling outside the scope of the duty of care in the tort of negligence or to make a complaint at the level of the Nigerian Constitution or in respect of one of the international human rights treaties ratified by Nigeria, which only very rarely yields a meaningful level of monetary compensation. (As I mentioned in my introduction to this thesis, I propose a legislative model at the conclusion of the thesis designed to deal with this problem, so far as is practicable.)

### *1. The Right to Health in International Human Rights Law*

The right to health is one of the most important of economic and social rights recognised in international human rights instruments.<sup>71</sup> Other rights include the

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<sup>71</sup> General Comment No.14 (Twenty-second session, 2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), at para 3. Later in this chapter, reference will be made to the constitutions of some countries which provide express protection to the right to health. Even in countries which do not contain such a provision, some protection is nonetheless afforded to the right to

right to work, the right to housing and the right to social welfare. These human rights are also protected by instruments such as the Constitution of the World Health Organization<sup>72</sup>, which regulates the right to health and health related matters. The Universal Declaration of Human Rights (UDHR)<sup>73</sup> articulates the core elements of public health concerns. While not a treaty creating a set of binding obligations, it is universally accepted as a fundamental human rights document, inspiring the formulation of such crucial instruments as the International Covenant on Civil and Political Rights<sup>74</sup>, the United Nations Convention on the Rights of the Child<sup>75</sup>, and the International Covenant on Economic, Social and Cultural Rights<sup>76</sup>.

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health or healthcare, albeit under some other characterisation. For example, the US Constitution does not provide for an express right to health but the government has an obligation to provide medical care in limited circumstances, such as the duty to provide such care to prisoners. In *Estelle v Gamble* (1976) 429 U.S. 97, at 103, the Supreme Court of United States stated: "... elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical 'torture or a lingering death'."

<sup>72</sup> 1946 states amongst its underlying principles: The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

<sup>73</sup> 1948. Article 25(1) states: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

<sup>74</sup> 1966.

<sup>75</sup> 1989. Article 24 states: (1) States parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. (2) States parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: (a) To diminish infant and child mortality; (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care; (c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environment pollution; (d) To ensure appropriate pre-natal and post-natal health care for mothers; (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents; (f) To develop preventive health care, guidance for parents and family planning education and services. (3) States parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children. (4) States parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

<sup>76</sup> 1966. Article 12 – (1) The States parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2) The steps to be taken by the States parties to the Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The

The UDHR has also inspired other international human rights instruments containing provisions protecting the right to health, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)<sup>77</sup>, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment<sup>78</sup>, the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care<sup>79</sup>, and the UN Convention on the Rights of Persons with Disabilities<sup>80</sup>.

The right to health is also recognised in regional treaties, including the European Convention on Human Rights (ECHR)<sup>81</sup>, the European Social Charter (Revised)<sup>82</sup>,

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improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

<sup>77</sup> 1981. Article 10(h) – Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning. In *Szijjarto v Hungary* (U. N. Doc. A/61/38, 2006), the complainant alleged the defendant for violation of right to her health on account that she was not fully informed of the consequences related to the sterilization procedure which she underwent. The Committee in its view found that the hospital staff failed to inform the complainant adequate counselling and information about the sterilization, as well as the risks involved in the procedure. In determining liability, the Committee directed its mind to the provisions of Article 12 of CEDAW together with the explanatory note in relation to Article 12 on women and health (General Recommendation No.24, at para 22) held the defendant liable. It stated, “The Committee considers in the present case that the State party has not ensured that the author gave her full informed consent to be sterilized and that consequently the rights of the author under article 12 were violated.”

<sup>78</sup> 1987. Article 2 – (1) Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction. (2) No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture. (3) An order from a superior officer or a public authority may not be invoked as a justification of torture.

<sup>79</sup> 1991. Principle 1 – Fundamental freedoms and basic rights. (1) All persons have the right to the best available mental health care, which shall be part of the health and social care system. Principle 8 – Standard of care: (1) Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons. (2) Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

<sup>80</sup> 2007. Article 17 – Protecting the integrity of the person: Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

<sup>81</sup> 1953. Recognition of the right is indirect, it is limited to civil and political rights. However, the European Court of Human Rights established that deprivation of a duty to take care amounted to a violation of socio-economic rights in *Airey v Ireland* [1979] ECHR 3. The defendant argued that the Convention should not be interpreted as to achieve social and economic rights. The European Court of Human Rights noted (at para 26), that many of civil and political rights has underlying obligations with social and economic rights. It stated: “The Court is aware that the further realisation of social and economic rights is largely dependent on the situation – notably financial – reigning in the State in question. On the other hand, the Convention must be interpreted in the light of present-day conditions ... and it is designed to safeguard the individual in a real and practical way as regards those areas with which it deals ... Whilst the Convention sets forth what are essentially civil and political rights, many of them have implications of a social or economic nature. The Court therefore considers, like the Commission, that the mere fact that an

the African Charter on Human and Peoples' Rights<sup>83</sup>, and the African Charter on the Rights and Welfare of the Child<sup>84</sup>. The American Convention on Human Rights,<sup>85</sup> also provides protection for the right to health.

Other treaties at the sub-regional level include the Economic Community of West African States (ECOWAS)<sup>86</sup>.

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interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against such an interpretation; there is no water-tight division separating that sphere from the field covered by the Convention.” In *Tysiac v Poland* [2007] ECtHR 219 at para 124, the ECtHR examined the violation of the right to private life under Article 8 of the Convention in the context of abortion and found that Polish law did not contain any effective mechanisms capable of determining whether the conditions for obtaining a lawful abortion had been met. In *A, B & C v Ireland* [2010] ECHR 2032, at para 214, the ECtHR held that Article 8 cannot be interpreted as conferring a right to abortion. However, echoing the approach it had adopted in *Tysiac*, the court held that Ireland had violated the right of the third applicant, C to have clarity in the law as to the circumstances in which she was entitled to have access to abortion. For criticism from a liberal perspective of the courts' emphasis on procedural aspects and failure to confront the substantive normative issues, see Fenwick, 'Abortion jurisprudence' at *Strasbourg: deferential, avoidant and normatively neutral?* (2014) 34 *Legal Studies* 214.

<sup>82</sup> 1996. Part II, Article 11 – The right to protection of health: With a view to ensuring the effectiveness of the right to protection of health, the Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*: (1) to remove as far as possible the causes of ill-health; (2) to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; (3) to prevent as far as possible epidemic, endemic and other diseases, as well as accidents. The European Committee of Social Rights affirmed that the Charter complements the rights enshrined in ECtHR that must be interpreted so as to give effect to fundamental social rights in *International Federation of Human Rights Leagues (FIDH) v France* (Comm. No.14/2003). The complainants alleged a violation of medical assistance on the rights of illegal immigrants. The Committee (at para 31), stated, “Human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights and health care is a prerequisite for the preservation of human dignity.” The Court concluded that it was the opinion of the Committee that legislation or practice which denies entitlement to medical assistance to foreign national, within the territory of a State Party, even if they are there illegally, is contrary to the Charter.

<sup>83</sup> 1981. Article 16: (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health. (2) States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

<sup>84</sup> 1999. Article 14(1) Health and Health Services: Every child shall have the right to enjoy the best attainable state of physical mental and spiritual health.

<sup>85</sup> Article 10 provides: “(1) Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being. (2) In order to ensure the exercise of the right to health, the State Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right: (a) Primary health care, that is, essential health care made available to all individuals and families in the community; (b) Extension of the benefits of health services to all individuals subject to the State's jurisdiction; (c) Universal immunization against the principal infectious diseases; (d) Prevention and treatment of endemic, occupational and other diseases; (e) education of the population on the prevention and treatment of health problems, and (f) Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.” Article 11 provides: “(1) Everyone shall have the right to live in a healthy environment and to have access to basic public services. (2) The States Parties shall promote the protection, preservation, and improvement of the environment.” As in India jurisprudence, the Inter-American Court has interpreted the right to life under the Constitution as embracing the right to a dignified life, which includes a requirement for adequate protection of a person's health: See Keener & Vasquez, *A Life Worth Living: Enforcement of The Right To Health Through The Right To Life In The Inter-American Court Of Human Rights* (2009) 40 *Columbia Human Rts L Rev* 595.

Under Article 2(1), the International Covenant on Economic, Social and Cultural Rights is the most important and influential instrument. Each State party undertakes:

*“to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”*<sup>87</sup>

This principle implies that the rights under the Covenant are subject to “progressive realization” of the rights having regard to the limited resources that may be available within the particular state<sup>88</sup>, with equitable distribution of healthcare facilities and health policy decisions.<sup>89</sup> The progressive realization of the rights imposes an obligation on the States parties to guarantee equal treatment without

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<sup>86</sup> 1975. Comprising 15 members: The Republic of Benin, Burkina Faso, Cape Verde, Cote D’Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo. (Mauritania left in 2002).

<sup>87</sup> *International Covenant on Economic, Social and Cultural Rights* (1966).

<sup>88</sup> General Comment No.14 (Twenty-second session, 2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), at para 47, states: “A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above.”

<sup>89</sup> Amnesty International, *Human rights for human dignity: A primer on economic, social and cultural rights*. (Amnesty International Publications, London, 2005) 1, at 3, states: “Gross economic and social inequality is an enduring reality in countries of all political colours, and all levels of development. In the midst of plenty, many are still unable to access even minimum levels of food, water, education, health care and housing. This is not only the result of a lack of resources, but also unwillingness, negligence and discrimination by governments and others. Many groups are specifically targeted because of who they are; those on the margins of society are often overlooked altogether.”



discrimination<sup>90</sup> and to take reasonable steps within a short time after entry into the Covenant to achieve the rights progressively.<sup>91</sup>

The mechanism for ensuring that states comply with their obligations under international human rights instruments is weak. A State party can be held liable for the breach of the obligations under the International Covenant on Economic, Social and Cultural rights if the State Party concerned has adopted the Optional Protocol to the Covenant<sup>92</sup>, which allows individual complaints to seek redress for the violation of socio-economic and cultural rights under the Covenant.<sup>93</sup> It is significant to note that Nigeria has not yet ratified, or even signed, the Optional Protocol.

The Committee on Economic, Social and Cultural Rights is charged with task of monitoring the rights and obligations undertaken by States parties to the International Covenant on Economic, Social and Cultural Rights. It has expanded upon the scope of the right to health<sup>94</sup> notwithstanding the principle of progressive

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<sup>90</sup> *International Covenant on Economic, Social and Cultural Rights* (1966) Article 2(2) states: The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

<sup>91</sup> General Comment No.3 (Fifth Session, 1990): The Nature of States Parties' Obligations, at para 2, states: [W]hile the full realization of the relevant rights may be achieved progressively, steps towards that goal must be taken within a reasonably short time after the Covenant's entry into force for the States concerned. Such steps should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.

<sup>92</sup> Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (2008), Article 1.

<sup>93</sup> To date 21 countries have ratified the Optional Protocol. Amnesty International, *Bringing ESC Rights Home: Ireland And The Optional Protocol To The International Covenant On Economic, Social and Cultural Rights* (2014)1, at p 16 notes: "To date, 15 States (Spain, Portugal, Slovakia, Montenegro, Bosnia and Herzegovina, Finland, Belgium, Uruguay, Mongolia, Ecuador, El Salvador, Bolivia (Plurinational State of), Argentina, Gabon, Cape Verde [Costa Rica, France, Italy, Luxembourg, Niger, San Marino] )." Noting (at p 16) that: "A further 30 States (Angola, Armenia, Azerbaijan, Benin, Burkina Faso, Chile, Congo, Democratic Republic of Congo, Ghana, Guatemala, Guinea-Bissau, Ireland, Kazakhstan, Madagascar, Maldives, Netherlands, Paraguay, Senegal, Slovenia, Solomon Islands, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Ukraine, Venezuela (Bolivarian Republic of)), including Ireland, have signed the OP ICESCR but have not yet ratified it."

[https://treaties.un.org/Pages/Viewdetails.aspx?src=TREATY&mtdsg\\_no=IV-3-a&chapter=4&lang=en](https://treaties.un.org/Pages/Viewdetails.aspx?src=TREATY&mtdsg_no=IV-3-a&chapter=4&lang=en)>. The unimpressive number of African States that have ratified, or even signed, the Protocol is noteworthy.

<sup>94</sup> General Comment No.14 (Twenty-second session, 2000) outlines the framework of the right to the highest attainable standard of health in Article 12 ICESCR with a detailed explanation and its implications. The Committee (at para 4), stated: In drafting article 12 of the Covenant, the Third Committee of the United Nations General Assembly did not adopt the definition of health contained in the preamble to the Constitution of WHO, which conceptualizes health as "a state of complete physical, mental and social well-being and not merely the absence of disease or

realization in terms of resource constraints<sup>95</sup> to include underlying determinants of health<sup>96</sup> and reinforced the importance of *minimum core obligations*<sup>97</sup> on States parties to provide, at the very least, the minimum standard obligations which are largely determined by the needs of the most vulnerable groups in the society that are entitled to the protection of the right in question through their limited resources for the rights of their people.<sup>98</sup> The *minimum core obligations* imposed on States

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infirmity". However, the reference in article 12(1) of the Covenant to "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12(2) acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

<sup>95</sup> *Purohit & Anor v The Gambia* (2003) AHRLR 96, at para 85. This case concerned the incarceration of mental health patients. The African Commission in response to the defence of resource constraints, stated: "This is ... not enough because the rights and freedoms of human beings are at stake. Persons with mental illness should never be denied their right to proper health care, which is crucial for their survival and their assimilation into and acceptance by the society."

<sup>96</sup> General Comment No.14 (Twenty-second session, 2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), at para 8, states: The right to health is not to be understood as a right to be *healthy*. The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

<sup>97</sup> General Comment No.14 (Twenty-second session, 2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), at para 43, states: In General Comment No. 3, the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. Read in conjunction with more contemporary instruments, such as the Programme of Action of the International Conference on Population and Development, the Alma-Ata Declaration provides compelling guidance on the core obligations arising from article 12. Accordingly, in the Committee's view, these core obligations include at least the following obligations: (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) To ensure access to the minimum essential food which is nutritiously adequate and safe, to ensure freedom from hunger to everyone; (c) To ensure access to basic shelter, housing and sanitation, and adequate supply of safe and portable water; (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; (e) To ensure equitable distribution of all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

<sup>98</sup> General Comment No.3 (Fifth session, 1990): The Nature of States Parties' Obligations, at para 10, states: [T]he Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it

parties to fulfil their obligations are taken as a minimum standard of a right which individuals under any circumstance are entitled to enjoy the right in question, in which the State party cannot compromise regardless of the economic measure in operation.<sup>99</sup>

The Committee acknowledges that resources are never sufficient in any given situation to meet demands fully but emphasises the need for States parties to

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would be largely deprived of its *raison d'être*. By the same token, it must be noted that any assessment as to whether a State has discharged its minimum core obligation must also take account of resources constraints applying within the country concerned. Article 2(1) obligates each State party to take the necessary steps 'to the maximum of its available resources'. In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.

<sup>99</sup> See generally Audrey R. Chapman, *A "Violations Approach" for Monitoring the International Covenant on Economic, Social and Cultural Rights* (1996) 18(1) Human Rights Quarterly 23. The judicial inquiry in determining the standard test in the context of minimum *core obligations* of the rights is unclear (*Cf* Sandra Kiapi, *Interpreting The Right To Health Under The African Charter* (2005) 11(1) East African Journal of Peace & Human Rights 1, at 6-7) as the decisions of the courts were mostly deferential to the approach of a reasonable measures taken by the State party rather than individualistic approach to set benchmarks (*Cf* Karin Lehmann, *In Defence of the Constitutional Court: Litigating Socio-Economic Rights and the Myth of the Minimum Core* (2006) 22 American U. Int'l L Rev 163, at 182). There must be a universal standard as benchmarks irrespective of the economic well-being of State parties to determine the breach of minimum *core obligations* arising from the progressive realisation of the rights as opposed to applying a different standard on account of political or economic system of the State party. In *Government of the Republic of South Africa & Ors v Grootboom & Ors* [2000] ZACC 19, the plaintiffs alleged the defendants for failure to provide adequate housing unit which they were entitled to by reason of the minimum core obligation incurred by the state under section 26 of the South African Constitution 1996. The South African Constitutional Court, in analysing the core contents of the minimum core obligations was of the opinion that such a decision requires the consideration of some variables in reference to the varying degree of needs by the claimants in the society. Thus, the Constitutional Court adopted a reasonable measure standard for fulfilling the requirements of minimum core obligations. Yacoob J (at para 32-33), noted: "It is not possible to determine the minimum threshold for the progressive realisation of the right to access to adequate housing without first identifying the needs and opportunities for the enjoyment of such a right. These will vary according to factors such as income, unemployment, availability of land and poverty. The differences between city and rural communities will also determine the needs and opportunities for the enjoyment of this right. Variations ultimately depend on the economic and social history and circumstances of a country. All this illustrates the complexity of the task of determining a minimum core obligation for the progressive realisation of the right of access to adequate housing without having the requisites information on the needs and the opportunities for the enjoyment of this right. ... The determination of a minimum core in the context of 'the right to have access to adequate housing' presents difficult questions. This is so because the needs in the context of access to adequate housing are diverse: there are those who need land; others need both land and houses; yet others need financial assistance. There are difficult questions relating to the definition of minimum core in the context of a right to have access to adequate housing, in particular whether the minimum core obligation should be defined generally or with regard to specific groups of people. ... the real question in terms of our Constitution is whether the measures taken by the state to realise the right afforded by section 26 are reasonable. There may be cases where it may be possible and appropriate to have regard to the consent of a minimum core obligation to determine whether the measures taken by the state are reasonable. However, even if it were appropriate to do so, it could not be done unless sufficient information is placed before a court to enable it to determine the minimum core in any given context. In this case, we do not have sufficient information to determine what would comprise the minimum core obligation in the context of our Constitution. It is not in any event necessary to decide whether it is appropriate for a court to determine in the first instance the minimum core content of the right." See also *Mazibuko & Ors v City of Johannesburg & Ors* [2009] ZACC 28.

prioritize the allocation of scarce resources to protection of the right to health so as to yield a maximum of its available resources.

The Committee has enlarged upon the legal obligations falling on State Parties:

*“The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to **respect**, **protect** and **fulfil**. In turn, the obligation to fulfil contains obligations to facilitate, provide and promote.<sup>100</sup> The obligation to **respect** requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to **protect** requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to **fulfil** requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.”<sup>101</sup>*

The Committee has emphasised the importance of access to judicial remedies<sup>102</sup> for the rights considered justiciable in accordance with national legal system operating in States parties for the enforcement of the violation of the right to health.

Justiciability strengthens the scope and effectiveness of right to health by its recognition at national level, especially where it enables the courts to adjudicate on

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<sup>100</sup> According to General Comments Nos.12 and 13, the obligation to fulfil incorporates an obligation to *facilitate* and an obligation to *provide*. In the present General Comment, the obligation to fulfil incorporates an obligation to *promote* because of the critical importance of health promotion in the work of WHO and elsewhere.

<sup>101</sup> General Comment No.14 (Twenty-second session, 2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), at para 33.

<sup>102</sup> *Ibid.*, at para 59, states: Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients’ rights associations or similar institutions should address violations of the right to health.

the violation of the right to health by direct reference to the International Covenant on Economic, Social and Cultural Rights. It should be acknowledged, nonetheless, that the Covenant does not expressly *require* that the rights recognised, including the right to health, should actually be justiciable. A state, such as Nigeria (or Ireland, for example) which either by express constitutional or legislative provisions excludes such justiciability or where Constitution is interpreted by the courts as excluding such justiciability will not on that account be in breach of its Treaty obligations.

The African Charter on Human and Peoples' Rights expressly guarantees both civil and political rights and socio-economic rights as enforceable rights, unlike in certain other regional treaties, where socio-economic rights are not expressly protected, most notably the European Convention on Human Rights<sup>103</sup>.

The African Charter specifically recognises the right to health<sup>104</sup> in Article 16<sup>105</sup> (and this right has been further advanced by the later Protocol to the Charter on the

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<sup>103</sup> 1953. The European Court of Human Rights has, however, interpreted a number of provisions – notably Articles 3 and 8 – of the Convention as affording protection to economic and social rights in particular contexts. See *D v The UK* (2 May 1997) ECtHR, at para 53. Contrast with *N v The UK* (27 May 2008) ECtHR, at para 51, states, “In the Court’s view, the applicant’s case cannot be distinguished from those cited in ... It does not disclose very exceptional circumstances, such as in *D v The United Kingdom* (2 May 1997), and the implementation of the decision to remove the applicant to Uganda would not give rise to a violation of Article 3 of the Convention.”

<sup>104</sup> References to the Charter, and particularly the right to health.

<sup>105</sup> 1981. Ebenezer Durojaye, *The approaches of the African Commission to the right to health under the African Charter* (2013) 17 *Law, Democracy & Development* 393, at 397, states: “[S]light differences exist in the language used when compare with that of Article 12 of the ICESCR. First, while the provision of the ICESCR is addressed to states (duty-bearers), the first part of Article 16 of the African Charter focuses on ‘every individual’ (right-holders). In essence, while it would seem that the ICESCR is more concerned with holding states parties to the treaty accountable, Article 16 of the Charter would seem to lay emphasis on the real enjoyment of rights by individuals. For the purposes of monitoring human rights, these two approaches are relevant. However, since states are the subject of international law, it is assumed that the focus on individuals does not in any way diminish the obligations imposed on states parties to the African Charter. Indeed, the language of the second part of Article 16 supports this submission. ... Secondly, the specific reference to medical attention for those who are sick would seem to suggest more attention to curative rather than preventive medical services. This provision is not as detailed as Article 12(2) of the ICESCR and makes no reference to underlying determinants of health, such as, healthy environment, water and sanitation and prevention, treatment and control of epidemic. More importantly, Article 16 of the African Charter fails to address issues, such as, maternal and infant mortality, access to contraception and HIV/AIDS. In particular, these issues affect women more than men in Africa. Given that these are serious health that affect Africa more than other regions, it is a serious omission on the part of the drafters of the Charter, although one may argue that at the

Rights of Women).<sup>106</sup> Other provisions<sup>107</sup> in the Charter also impact on the right to health by bolstering its protection from different perspectives.<sup>108</sup>

Thus, the African Commission had adopted both an indivisibility approach<sup>109</sup>, by regarding a violation of the right to health as being capable of being considered a

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time the Charter was being finalised HIV/AIDS had not become a major challenge in the region. However, it is inexplicable that issues, such as, infant and maternal mortality, which have always posed great challenges in the region, were not addressed in the Charter. An alternative argument to this would be that the non-specific mention of these issues should not prevent a broad interpretation of Article 16 to include them. ... Article 14 of the African Women's Protocol contains one of the most comprehensive provisions on the right to health and sexual and reproductive health under international human rights law.”

<sup>106</sup> Protocol to the African Charter on Human and Peoples' Rights of Women in Africa (2005). Article 14 – Health and Reproductive Rights: (1) State Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes: (a) the right to control their fertility; (b) the right to decide whether to have children, the number of children and the spacing of children; (c) the right to choose any method of contraception; (d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; (e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; (f) the right to have family planning education. (2) States Parties shall take all appropriate measures to: (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; (b) establish and strengthen existing pre-natal, delivery and post-natal health nutritional services for women during pregnancy and while they are breast-feeding; (c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or life of the mother or the foetus.

<sup>107</sup> Protocol to the African Charter on Human and Peoples' Rights of Women in Africa (2005), Article 62 states: Every state party shall undertake to submit every two years, from the date the present Charter comes into force, a report on the legislative or other measures taken with a view to giving effect to the rights and freedoms recognized and guaranteed by the present Charter.

<sup>108</sup> In *Free Legal Assistance Group & Ors v Zaire* (Comm. Nos.25/89, 47/90, 56/91, 100/93) 1995, the complainants alleged varying degree of human rights abuses, including torture, extrajudicial executions, arbitrary arrests against freedom of conscience and failure of the government to provide basic services – safe drinking water, electricity and shortage of medicine. The Commission found that the right to health gives rise to such rights and held that the failure to provide basic health services constituted a violation of Articles 4, 5, 6, 7, 8, 16 and 17 of the African Charter. In *Sudan Human Rights Organisation & Centre on Housing Rights and Evictions (COHRE) v The Sudan* (Comm. Nos.279/03 & 296/05) 2009, the complainants alleged human rights violations, including destruction of homes, water wells, livestock and farms. The Commission in examining the context of the alleged violations of human rights in reference to Article 16 of the African Charter established the normative definition of the right to health that it includes both healthcare and healthy conditions. It held (at para 212): “[T]he destruction of homes, livestock and farms as well as the poisoning of water sources, such as wells exposed the victims to serious health risks and amounts to a violation of Article 16 of the Charter.”

<sup>109</sup> *SERAC v Nigeria* (2001) AHRLR 60, at para 44. The Inter-American Court of Human Rights had adopted a similar approach in *Villagran-Marales et al v Guatemala* (19 November 1999). The complainants were minors when they were abducted, tortured and murdered. The defendant was found liable for the loss of life arising from the alleged treatment suffered by the victims. The Inter-American Court stated: “The right to life is a fundamental human right, and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lacking meaning. Owing to the fundamental nature of the right to life, restrictive approaches to it are inadmissible. In essence, the fundamental right to life includes, not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. States have the obligation to guarantee the creation of the conditions required in

violation of other rights traditionally characterised as civil rather than social, and an "underlying determinant of health"<sup>110</sup> approach in interpreting the right to health under the provisions of the African Charter.

In *Malawi African Association & Ors v Mauritania*,<sup>111</sup> the complainants in a class of action alleged human rights abuses under the African Charter on Human and Peoples' Rights in that some prisoners were made to sleep on the floor without any blankets, the cells were infested and nothing was done to provide access for the prisoners to medical treatment, among other claims. The Commission, in assessing the extent of the violation of the rights, stated:

*"Denying people of food and medical attention, burning them in sand and subjecting them to torture to the point of death point to a shocking lack of respect for life, and constitutes a violation of Article 4."*<sup>112</sup>

In its Conclusions, the Commission reinforced the protection of the right to health and held the defendant liable on its violation of the right under Article 16 of the Charter<sup>113</sup>.

In *Purohit and Moore v The Gambia*,<sup>114</sup> the complainants were mental health advocates, submitting the communication on behalf of patients detained at

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order that violations of this basic right do not occur and, in particular, the duty to prevent its agents from violating it."

<sup>110</sup> *Free Legal Assistance Group & Ors v Zaire* (Comm. Nos. 25/89, 47/90, 56/91, 100/93) 1995. Similarly in *Sudan Human Rights Organisation & Centre on Housing Rights and Eviction (COHRE) The Sudan* (Comm. Nos. 279/03 & 296/05) 2009, at para 209, the African Commission, in reference to international and regional human rights instruments, including the African Charter in the context of Article 16, remarked: "In its *General Comment No. 14* on the right to health adopted in 2000, the UN Committee on ESCR sets out that, 'the right to health extends not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and portable water, an adequate supply of safe food, nutrition, and housing ...'."

<sup>111</sup> (2000) AHRLR 149.

<sup>112</sup> *Malawi African Association & Ors v Mauritania* (2000) AHRLR 149, at para 120.

<sup>113</sup> *Ibid.*, at para 122, the Commission stated: "[T]he physical integrity and welfare of detainees is the responsibility of the competent public authorities. Some prisoners died as a result of the lack of medical attention. The general state of health of the prisoners deteriorated due to the lack of sufficient food; they had neither blankets nor adequate hygiene."

Campana, a Psychiatric Unit of the Royal Victoria Hospital in Banjul, and existing and ‘future’ mental health patients detained under the Mental Health Acts of the Republic of The Gambia. The complainants alleged a violation of Articles 2, 3, 5, 7(1)(a) and (c), 13(1), 16 and 18(4) of the African Charter on Human and Peoples’ Rights.

The Commission considered whether there were available remedies to the Complainants in the national constitution and held the view that the remedies (of constitutional litigation and tort actions for false imprisonment) were not realistic as those most likely to be incarcerated – poor people lacking education or economic resources – would not be likely to be capable of accessing these remedies.<sup>115</sup> The Commission found that the position in The Gambia fell short of satisfying the requirements of Articles 16 and 18(4) of the African Charter. The Commission held that the enjoyment of the human right to health is crucial to the realisation of other fundamental human rights freedoms and this includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind<sup>116</sup>. The Commission stated:

*“The Principles envisage not just ‘attainable standards’, but the the highest attainable standards of health care for the mentally ill at three levels. First, in the analysis and diagnosis of a person’s mental*

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<sup>114</sup> (2003) AHRLR 96.

<sup>115</sup> Andrew Hudson Westbrook, *Mental Health Legislation and Involuntary Commitment in Nigeria: A Call for Reform* (2011) 10 Washington University Global Studies Law Review 397, at 410-411 states, “[T]he Constitution of Nigeria excludes persons of ‘unsound mind’ when detained for the ‘purpose of their care or treatment or the protection of the community.’ Beyond its own Constitution, Nigeria has entered into two binding international legal agreements that govern human rights and provide general principles by which to judge any Nigerian mental health law. First, the International Covenant on Economic, Social and Cultural Rights (ICESCR) ‘recognize[s] the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’ ... Second, Nigeria has also committed to recognize and give effect to the rights declared in the African Charter on Human and Peoples’ Rights. Beyond including language identical to that of the ICESCR, as quoted above, the Charter provides for the general right to an environment favourable to further development and specifically requires ‘special measures of protection’ for the disabled.”

<sup>116</sup> *Purohit and Moore v The Gambia* (2003) AHRLR 96, at para 80.



*condition; second, in the treatment of that mental condition and; thirdly, during the rehabilitation of a suspected or diagnosed person with mental health problems.*”<sup>117</sup>

The Commission, recognising the absence of therapeutic objectives coupled with the limited resources available in African countries made it difficult for the citizenry to obtain optimum healthcare and in the absence of express notion of “progressive realisation”<sup>118</sup> subject to available resources, read into Article 16 the obligation on part of a State party to the African Charter to:

*“take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind.”*<sup>119</sup>

It might be considered that this proposition implies the concept of reasonable steps through progressive realization<sup>120</sup> of the rights recognized by the African Charter.<sup>121</sup> This is so even though the Charter does not actually prescribe, *expressis*

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<sup>117</sup> *Ibid.*, at para 82. In a related case, the Inter-American Commission on Human Rights in *Victor Rosario Congo v Ecuador* (13 April 1999) Report No. 63/99, Case No. 11.427. The complainant was charged with robbery and assault and placed in detention where he developed mental illness and subsequently died in detention. The complainant alleged infliction of bodily injuries, lack of medical attention, isolation, and negligence arising from his death. The Inter-American Commission in its analysis considered the question whether the complainant’s fundamental rights had been violated in reference to the right to humane treatment, the right to life and the right to judicial protection. The Commission reached a conclusion that the defendant had violated the complainant’s rights, it held: “Provide medical and psychiatric care for persons suffering from mental illness and confined in penitentiary facilities.”

<sup>118</sup> International Covenant on Economic, Social and Cultural Rights (1966), Article 2(1) states: Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

<sup>119</sup> *Purohit and Moore v The Gambia* (2003) AHRLR 96, at para 84.

<sup>120</sup> *Cf* General Comment No. 14, at para 47.

<sup>121</sup> Pretoria Declaration on Economic, Social and Cultural Rights in Africa (2004), at para 11(c)(iv), states: Address economic, social and cultural rights during the examination of State Reports under article 62 during questions and concluding observation.

*verbis*, that states are required to take reasonable legislative or other measures to realize these rights.<sup>122</sup>

In *International Pen & Ors v Nigeria*,<sup>123</sup> a complaint was lodged on behalf of Ken Saro Wiwa, a writer, environmentalist and president of the Movement for the Survival of the Ogoni People (MOSOP). While he was in detention awaiting execution with others, his health condition deteriorated and his requests for medical attention were denied. The Commission held the Nigerian government liable for violated the complainant's right to health under Article 16 of the African Charter. The Commission stated:

*“The responsibility of the government is heightened in cases where an individual is in its custody and therefore someone whose integrity and well-being is completely dependent on the actions of the authorities. The state has a direct responsibility in this case. Despite requests for hospital treatment made by a qualified prison doctor, these were denied to [Ken Saro Wiwa], causing his health to suffer to the point where his life was endangered. ... This was a violation of Article 16.”*<sup>124</sup>

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<sup>122</sup> Frans Viljoen, *International Human Rights Law in Africa* (2<sup>nd</sup> ed, Oxford University Press 2012), at 217, argues that: “The Charter does not make the ‘fulfilment’ of any of its provisions dependent on ‘available resources’ or ‘progressive realization’. In this respect – as far as ‘socio-economic’ rights are concerned – the Charter deviates from the ICESR. It appears that the Commission, actually conscious of the prevalence of the ‘problem of poverty’, entertained some doubt about the feasibility of altogether dispensing with those elements. It therefore decided to ‘read into’ the right to health the qualification of ‘available resources’. At the same time, it imported from the Committee on Economic, Social and Cultural Rights the notion that states retain the ‘core’ obligation to take concrete, targeted, and non-discriminatory steps. It may be argued that this interpretation is influenced by the wording of article 16, which provides for the ‘best attainable’ state of health and ‘necessary measures’, and is therefore not a general statement about the duty to ‘fulfil’ rights. The qualification of ‘available resources’ should therefore not, on the basis of this decision, be applied to the ‘unqualified’ right to education.”

<sup>123</sup> (1998) Comm. Nos.137/94, 139/94, 154/96 and 161/97.

<sup>124</sup> *International Pen & Ors v Nigeria* (1998) Comm. Nos. 137/94, 139/94, 154/96 and 161/97, at para 112.

The general obligation of States parties in African Charter on Human and Peoples' Rights<sup>125</sup> to prevent all forms of human rights violations was explained in *SERAC v Nigeria*.<sup>126</sup> The complainants alleged that the Nigerian government had violated the right to health and the right to a clean environment<sup>127</sup> as recognised under Articles 2, 4, 14, 16, 18(1), 21, and 24 of the African Charter by failing to fulfil the minimum duties required by the recognition of these rights.<sup>128</sup>

The Commission observed that the Nigerian government had incorporated the African Charter on Human and Peoples' Rights into its domestic law,<sup>129</sup> with the result that all rights contained therein could be invoked in Nigerian courts including those violations alleged by the complainants. The Commission was of the view that there were no adequate remedies when the complaint was lodged following the military intervention which ousted the jurisdiction of the courts.

In deciding the substantive merits of the complaint, the Commission considered the layers<sup>130</sup> of obligations of the governments under the African Charter with specific reference to the rights therein. The Commission observed:

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<sup>125</sup> 1981. Article 1 states: The Member States of the Organization of African Unity parties to the present Charter shall recognize the rights, duties and freedoms enshrined in this Chapter and shall undertake to adopt legislative or other measures to give effect to them.

<sup>126</sup> (2001) AHRLR 60.

<sup>127</sup> 1999 Constitution of Nigeria does not provide for express recognition of the right to a clean and healthy environment other than reliance on the same rights and obligations in accordance with the provisions of the African Charter. However, s. 20 (Environmental Objectives) of Nigerian Constitution, provides: The State shall protect and improve the environment and safeguard the water, air and land, forest and wild life of Nigeria.

<sup>128</sup> See analysis generally: James Donnelly-Saalfeld, *Irreparable Harms: How the Devastating Effects of Oil Extraction in Nigeria Have Not Been Remedied by Nigerian Courts, the African Commission, or U.S. Courts* (2009) 15 West-Northwest J of Environmental L Sc Policy 371.

<sup>129</sup> *Abacha v Fawehinmi* (2000) 4 FWLR 533, at para 14.

<sup>130</sup> *SERAC v Nigeria* (2001) AHRLR 60, at para 45-47, stated: "At a primary level, the obligation to **respect** entails that the State should refrain from interfering in the enjoyment of all fundamental rights; it should respect right-holders, their freedoms, autonomy, resources, and liberty of their action. With respect to socio economic rights, this means that the State is obliged to respect the free use of resources owned or at the disposal of the individual alone or in any form of association with others, including the household or the family, for the purpose of rights-related needs. And with regard to a collective group, the resources belonging to it should be respected, as it has to use the same resources to satisfy its needs. At a secondary level, the State is obliged to **protect** right-holders against other subjects by legislation and provision of effective remedies. This obligation requires the State to take measures to protect beneficiaries of the protected rights against political, economic and social interferences. Protection generally entails the creation and maintenance of an atmosphere or framework by an effective interplay of laws and regulations so that individuals will be able to freely realize their rights and freedoms. This is very much intertwined with tertiary

*“[A]ll rights – both civil and political rights and social and economic – generate at least four levels of duties for a State that undertakes to adhere to a rights regime, namely the duty to respect, protect, promote, and fulfil these rights. These obligations universally apply to all rights and entail a combination of negative and positive duties.”<sup>131</sup>*

The Commission in its analysis of environmental rights identified a substantive right – the right to a clean and healthy environment. It imposed liability on the Nigerian government for its failure on its part to take steps and to create awareness against risks of environmental degradation and the oil companies are liable for the destruction of the Ogoniland as a result of the environmental damage caused by the degradation of oil production and exploration<sup>132</sup>. It concluded:

*“Governments have a duty to protect their citizens, not only through appropriate legislation and effective enforcement but also by protecting them from damaging acts that may be perpetrated by private parties ... This duty calls for positive action on part of*

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obligation of the State to **promote** the enjoyment of all human rights. The State should make sure that individuals are able to exercise their rights and freedoms, for example, by promoting tolerance, raising awareness, and even building infrastructures. The last layer of obligation requires the State to **fulfil** the rights and freedoms it freely undertook under the various human rights regimes. It is more of a positive expectation on the part of the State to move its machinery towards the actual realisation of the rights. This is also very much intertwined with the duty to promote mentioned in the preceding paragraph. It could consist in the direct provision of basic needs such as food or resources that can be used for food (direct food aid or social security).”

<sup>131</sup> *Ibid.*, at para 44.

<sup>132</sup> *SERAC v Nigeria* (2001) AHRLR 60, at para 52-53, the African Commission, noted: “The right to a general satisfactory environment, as guaranteed under Article 24 of the African Charter or the right to a healthy environment, as it is widely known, therefore imposes clear obligations upon a government. It requires the state to take reasonable and other measures to prevent pollution and ecological degradation, to promote conservation, and to secure an ecologically sustainable development and use of natural resources. ... Government compliance with the spirit of Article 16 and Article 24 of the African Charter must also include ordering or at least permitting independent scientific monitoring of threatened environments, requiring and publicising environmental and social impact studies prior to any major industrial development, undertaking appropriate monitoring and providing information to those communities exposed to hazardous materials and activities and providing meaningful opportunities for individuals to be heard and to participate in the development decisions affecting their communities.”

*government in fulfilling their obligation under human rights instrument. ... By any measure of standards, its practice falls short of the minimum conduct expected of governments, and therefore, is in violation of Article 21 of the African Charter.”<sup>133</sup>*

At sub-regional level, the Economic Community of West African States (ECOWAS)<sup>134</sup> promotes economic integration in all aspect of economic activity which includes social and cultural matters of member states,<sup>135</sup> but, in keeping with the international treaties of which member states are States parties, embraces fundamental human rights as part of its objectives<sup>136</sup> and established common principles<sup>137</sup>. The ECOWAS Protocol on democracy and good governance provides:

*“[t]he rights set out in the African Charter on Human and Peoples’ Rights and other international instruments shall be guaranteed in each of the ECOWAS Member States; each individual or organization shall be free to have recourse to the common or civil law courts, a court of special jurisdiction, or any other national institution*

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<sup>133</sup> *Ibid.*, at para 57-58.

<sup>134</sup> 1975, carries out its functions under the following institutions: 1. The Commission (Secretariat), 2. The Community Parliament, 3. The Community Court of Justice, and 4, ECOWAS Bank for Investment and Development (EBID).

<sup>135</sup> Treaty of ECOWAS 1975, Article 3(1), states: The aims of the Community are to promote co-operation and integration, leading to the establishment of an economic union in West Africa in order to raise the living standards of its peoples, and to maintain and enhance economic stability, foster relations among Member States and contribute to the progress and development of the African Continent.

<sup>136</sup> ECOWAS, *Fourteenth Session Of The Authority of Heads of State And Government* (4-6 July 1991), Abuja. Declaration A/DCL.1/7/91 of Political Principles of The Economic Community of West African States: The preamble states: “... to promote democracy in the sub-region on the basis of political pluralism and respect for fundamental human rights as embodied in universally recognized international instruments on human rights and in the African Charter on Human and Peoples’ Rights”

<sup>137</sup> *Ibid.*, at para 5, states: “We will promote and encourage the full enjoyment by all our peoples of their fundamental human rights, especially their political, economic, social, cultural and other rights inherent in the dignity of the human person and essential to his free and progressive development.”

*established within the framework of an international instrument on Human Rights, to ensure the protection of his or her rights. In the absence of a court of special jurisdiction, the present Supplementary Protocol shall be regarded as giving the necessary powers to common or civil law judicial bodies.*”<sup>138</sup>

The ECOWAS Community Court of Justice was established<sup>139</sup> to hear, *inter alia*, cases relating to violations of human rights, after all attempts to resolve the matter at the national level have failed<sup>140</sup>. The Court has jurisdiction to determine cases of violation of human rights that occur in any Member State<sup>141</sup> in accordance with the ECOWAS Treaty and other International Treaties.<sup>142</sup>

In *SERAP v Federal Republic of Nigeria and Universal Basic Education Commission*,<sup>143</sup> in 2010, the plaintiff alleged violations of the human rights to education, and to human dignity, the right of peoples to their wealth and natural resources, and the right of people to economic and social development, all of which are guaranteed by Articles 1, 2, 17, 21 and 22 of the African Charter on Human and Peoples’ Rights. The defendants conceded that every Nigerian child is entitled to free and compulsory basic education, but contended that the right to education was non-justiciable. The Court held that, once the concerned right for which the protection is sought before the Court is enshrined in an international instrument that

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<sup>138</sup> (2001), Article 1(h).

<sup>139</sup> On 6 July 1991.

<sup>140</sup> ECOWAS Protocol on Democracy and Good Governance (2001), Article 39.

<sup>141</sup> Supplementary Protocol A/SP.1/01/05, Article 9(4).

<sup>142</sup> In *Ugokwe v Nigeria* (7 October 2005), the ECOWAS Community Court of Justice (at para 13) held: “The Federal Republic of Nigeria has infringed upon his right to fair hearing, which is a human right guaranteed by Article 7 of the African Charter of Human and Peoples’ Rights, on one hand, and by the Universal Declaration of Human Rights, on the other hand; and finally, turn was by Section 36 of the 1999 Constitution of the Federal Republic of Nigeria.”

<sup>143</sup> 30 November 2010 (ECOWAS Community Court of Justice).

is binding on a Member State, the domestic legislation of that State cannot prevail over the international treaty or covenant, even if it is its own constitution.

Two years later, in *SERAP v Federal Republic of Nigeria*,<sup>144</sup> the plaintiff alleged violations by the defendants of the rights to health, adequate standard of living and rights to economic and social development of the people of Niger Delta and the failure of the defendants to enforce laws and regulations to protect and prevent pollution.

The issue considered by the Court was not the allocation of resources to improve the quality of life of the people of Niger Delta but rather a failure to use the State authority, in compliance with international obligations, to prevent the oil extraction industry from doing harm to the environment, livelihood and quality of life to the people of Niger Delta. The Court observed:

*“[T]he duty assigned by Article 24 to each State Party to the Charter is both an obligation of attitude and obligation of result. The environment, as emphasised by the International Court of Justice, 'is not an abstraction but represents the living space, the quality of life and the very health of human beings, including generations unborn' ... The environment is essential to every human being. The quality human life depends on the quality of the environment. Article 24 of the Charter thus requires every State to take every measure to maintain the quality of the environment understood as an integrated whole, such that the state of the environment may satisfy the human beings who live there, and enhance their sustainable development. It is by examining the state of the environment and entirely objective factors, that one judges, by the result, whether the State has fulfilled this*

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<sup>144</sup> 14 December 2012 (ECOWAS Community Court of Justice).

*obligation. If the State is taking all the appropriate legislative, administrative and other measures, it must ensure that vigilance and diligence are being applied and observed towards attaining concrete results. ... as a State Party to the African Charter on Human and Peoples' Rights, the [defendant] is under international obligation to recognise the rights, duties and freedoms enshrined in the Charter and to undertake to adopt legislative or other measures to give effect to them.*"<sup>145</sup>

The Court concluded that:

*"... the [defendant], by comporting itself in the way it is doing, in respect of the continuous and unceasing damage caused to the environment in the Region of Niger Delta, has defaulted in its duties in terms of vigilance and diligence as party to the African Charter on Human and Peoples' Rights, and has violated Articles 1 and 24 of the said instrument.*"<sup>146</sup>

The decision stressed the State's minimum core obligation<sup>147</sup> to regulate the extractive oil and gas industry in order to prevent their effects on the environment and reparation for damage.

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<sup>145</sup> *SERAP v Federal Republic of Nigeria* (14 December 2012) ECOWAS Community Court of Justice, at paras 100-106.

<sup>146</sup> *Ibid.*, at para 112.

<sup>147</sup> *Ibid.*, at para 105, the Court stated: "[T]he adoption of the legislation, no matter how advanced it may be, or the creation of agencies inspired by the world's best models, as well as the allocation of financial resources in equitable amounts, may still fall short of compliance with international obligations in matters of environmental protection if these measures just remain on paper and are not accompanied by additional and concrete measures aimed at preventing the occurrence of damage or ensuring accountability, with effective reparation of the environmental damage suffered."



## 2. *The Right to Health in National Constitutions*

Many contemporary Constitutions, including those of Brazil<sup>148</sup>, Timor-Leste<sup>149</sup>, Nepal<sup>150</sup> and Bangladesh<sup>151</sup> contain provisions addressing the right to health, either as a free standing right<sup>152</sup> or as one of the Directive Principles on social and

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<sup>148</sup> 1988, Chapter II – Social Rights: Article 6 – Education, health, work, leisure, security, social security, protection of motherhood and childhood, and assistance to the destitute, are social rights, as set forth by this Constitution. Article 196 – Health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.

<sup>149</sup> 2002, Section 57 (Health): (1) Everyone has the right to health and medical care, and the duty to protect and promote them. (2) The State shall promote the establishment of a national health service that is universal and general. The national health service shall be free of charge in accordance with the possibilities of the State and in conformity with the law. (3) The national health service shall have, as much as possible, a decentralised participatory management.

<sup>150</sup> Interim Constitution 2007, Section 16 – Right Regarding Environment and Health: (1) Every person shall have the right to live in clean environment. (2) Every citizen shall have the right to get basic health service free of cost from the State as provided for in the law.

<sup>151</sup> 2004, Section 18 – Public health and morality: (1) The State shall regard the raising of the level of nutrition and the improvement of public health as moving its primary duties, and in particular shall adopt effective measures to prevent the consumption, except for medical purposes or for such other purposes as may be prescribed by law, of alcoholic and other intoxicating drinks and drugs which are injurious to health. (2) The State shall adopt effective measures to prevent prostitution and gambling.

<sup>152</sup> 1987 Constitution of Philippines, Article II – Declaration of Principles and State Policies: (S. 2) The Philippines renounces war as an instrument of national policy, adopts the generally accepted principles of international law as part of the law of the land and adheres to the policy of peace, equality, justice, freedom, cooperation, and amity with all nations. (S. 15) – State Policies: The State shall protect and promote the right to health of the people and instill health consciousness among them. The Supreme Court of Philippines in *James M. Imbong & Ors v Paquito N. Ochoa & Ors* (8 April 2014), delivered a landmark judgment concerning a Bill, Responsible Parenthood and Reproductive Health Act 2012 (RH Law). The petitioners alleged that: (1) The RH Law violates the right to life of the unborn ..., notwithstanding its declared policy against abortion, the implementation of the RH Law would authorize the purchase of hormonal contraceptives, intra-uterine devices and injectables which are abortives, in violation of S.12, Article II of the Constitution which guarantees protection of both the life of the mother and the life of the unborn from conception. (2) The RH Law violates the right to health and the right to protection against hazardous products. The petitioners posit that the RH Law provides universal access to contraceptives which are hazardous to one's health, as it causes cancer and other health problems. (3) The RH Law violates the right to religious freedom. The petitioners contend that the RH Law violates the constitutional guarantee respecting religion as it authorizes the use of public funds for the procurement of contraceptives. The petitioners urged the Court to declare the entire RH Law unconstitutional. The Supreme Court of Philippines was of the view that the issues of population growth control, abortion and contraception resulted in litigation. In consideration of the contentious issues with their exceptions, the Court stated that a component to the right to life is the constitutional right to health. It held that the Court did not find the RH Law unconstitutional insofar as it seeks to provide access to medically-safe, non-abortifacient, effective, legal, affordable, and quality reproductive healthcare services, methods, devices, and supplies. Mendoza J stated: "Be that as it may, it bears reiterating that the RH Law is mere compilation and enhancement of the prior existing contraceptive and reproductive health laws, but with coercive measures. Even if the Court decrees the RH Law as entirely unconstitutional, there will still be the Population Act, the Contraceptive Act, and the reproductive health for women or The Magna Carta of Women, sans the coercive provisions of the assailed legislation. All the same, the principle of 'no-abortion' and 'non-coercion' in the adoption of any family planning method should be maintained." In some countries, litigants have argued that the right to life embraces the right to a livelihood, on the basis that a person who lacks a livelihood is in such danger that his or her right to life is imperilled. The Supreme Court of India in *Olga Tellis v Bombay Municipality Corporation* [1985] 2 Supp SCR 51,

economic policy.<sup>153</sup> For example, in Ireland, the fundamental rights provisions of the 1937 Constitution provide for civil and political rights<sup>154</sup> while socio-economic rights are dealt with in Article 45<sup>155</sup>, which prescribes the Directive Principles and Social Policy.

Thus, there is no express recognition of right to health in the text of the Irish Constitution. But, in due course the courts developed a jurisprudence of recognising "unenumerated rights" under Article 40.3.1 of the Constitution, which embraced the right to health. In *Ryan v Attorney-General*,<sup>156</sup> the plaintiff alleged that the fluoridation of public water was a violation of her personal rights to bodily integrity. The Supreme Court, affirming Kenny J, was of the opinion that the "personal rights" guaranteed in the Constitution were not restricted to enumerated

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has interpreted the right to life that it includes the right to a livelihood on the basis of constitutional provisions. Chandrachud CJ stated: "If there is an obligation upon the State to secure to the citizens an adequate means of livelihood and the right to work, it would be sheer pedantry to exclude the right to livelihood from the content of the right to life. The State may not, by affirmative action, be compellable to provide adequate means of livelihood or work to the citizens. But, any person who is deprived of his right to livelihood except according to just and fair procedure established by law, can challenge the deprivation as offending the right to life conferred by Article 21." The Court of Appeal of Lesotho in *Baitsokoli & Anor v Maseru City Council & Ors* (2004) AHRLR 195, rejected this approach on the basis of its interpretation of the specific provisions in the Constitution dealing with the right to life and right to livelihood. Gauntlett JA (at paras 27-28), stated: "The factual premise for the present challenge is hardly comparable. The constitutional provisions differ materially. ... I accordingly consider that the right to life in section 5 of the Constitution of Lesotho does not encompass a right to a livelihood. That is the subject of specific and separate provision, in section 29. The latter derives its status from its inclusion as a principle of state policy. It is not included as a Chapter II right."

<sup>153</sup> Article 39 of India's Constitution, provides: "Certain principles of policy to be followed by the State: (e) that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength; (f) that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment." Article 47 provides: "Duty of the State to raise the level of nutrition and the standard of living and to improve public health: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purpose of intoxicating drinks and of drugs which are injurious to health." The Tanzanian Constitution 1995: Chapter 1, Part II, Article 9(i) provides: "[T]hat the use of national wealth places emphasis on the development of the people and in particular is geared towards the eradication of poverty, ignorance and disease."

<sup>154</sup> Articles 40-44.

<sup>155</sup> It states: The principles of social policy set forth in this Article are intended for the general guidance of the Oireachtas [Parliament]. The application of those principles in the making of laws shall be the care of the Oireachtas exclusively, and shall not be cognizable by any Court under any of the provisions of this Constitution.

<sup>156</sup> [1965] IR 294.

rights<sup>157</sup> under Article 40.3 of the Constitution. It affirmed the view of the trial judge that a right to bodily integrity was, among the personal rights guaranteed by the Constitution<sup>158</sup>. The Supreme Court held, on the evidence adduced, that water fluoridation was not an infringement to the plaintiff's right to bodily integrity<sup>159</sup>, though it left open the theoretical possibility that, at some future date, it might come to a different conclusion if the evidence adduced in such future litigation led to such an empirical conclusion.

Following this decision, the Supreme Court of Ireland further acknowledged the right to health as an unenumerated right under Article 40.3.1 of the Constitution in *Heeney v Dublin Corporation*.<sup>160</sup> There, O'Flaherty J stated:

*“It is beyond debate that there is a hierarchy of constitutional rights and at the top of the list is the right to life, followed by the right to health ...”*<sup>161</sup>

Courts in Ireland have tended to regard the right to bodily integrity as essentially coextensive with the right to health. Thus, in *The State (C.) v Frawley*,<sup>162</sup> concerned a prisoner with a personality disorder who had attempted to escape from prison and

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<sup>157</sup> *Ibid.*, at para 22, O'Dalaigh CJ stated: “To attempt to make a list of all the rights which may properly fall within the category of ‘personal rights’ would be difficult”

<sup>158</sup> *Ryan v Attorney-General* [1965] IR 294, at para 23, O'Dalaigh noted: “Kenny J held that a right to bodily integrity was, among the personal rights guaranteed by the Constitution, and he sought to define the right in these words: ‘I understand the right to bodily integrity to mean that no mutilation of the body or any of its members may be carried out on any citizen under authority of the law except for the good of the whole body and that no process which is or may, as a matter of probability, be dangerous or harmful to the life or health of the citizens or any of them may be imposed (in the sense of being made compulsory) by an Act of the Oireachtas’.”

<sup>159</sup> *Ibid.*, at para 32, O'Dalaigh CJ stated: “The Court is left in no doubt that the fluoridation of water to the extent proposed in the Dublin Health Authority area where the plaintiff resides cannot be said to involve physical changes which affect in any way either the wholeness or the soundness of the body of the person concerned. The ingestion of the fluoridated water cannot, therefore, be said to constitute an infringement of a failure to respect ... the bodily integrity of the plaintiff or the bodily integrity of her children.”

<sup>160</sup> 17 August 1998 (SC), at para 16.

<sup>161</sup> See generally *Irish Human Rights Commission* (2005) Making Economic, Social and Cultural Rights Effective: An IHRC Discussion Document, at p. 110.

<sup>162</sup> [1976] IR 365.

had made attempts to swallow objects that would require medical intervention to remove them. He challenged the lawfulness of his detention and argued that his right to bodily integrity had been violated on the basis that insufficient steps had been taken to respond to his particular medical condition and needs<sup>163</sup>. The Court was of the opinion that protection of the right to bodily integrity operated to prevent governmental action exposing the health of a person to risk or danger<sup>164</sup>. This approach has been criticised on the basis that right to bodily integrity and the

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<sup>163</sup> *The State (C) v Frawley* [1976] IR 365, Finlay P considered the reasonableness of the justiciability of the plaintiff's claim along with the larger needs of the society, held the view that it was not unreasonable if the Executive failed to provide the plaintiff a special psychiatric unit for his custody having regard to the small number of people involved in the society. Finlay P stated: "[T]he Executive had not failed in its duty on the basis that the State was not under the absolute duty to provide 'the best medical treatment irrespective of the circumstances'. It was 'not the function of the Court to recommend to the Executive what is desirable or to fix the priorities of its health and welfare policy'." Cf *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, at para 31. The Supreme Court of Ireland in *Sinnott v Minister for Education* [2001] 2 IR 505, rejected the justiciability of socio-economic rights. The trial court awarded the plaintiff who suffered severe autistic at birth, damages for past and future education. On appeal by the defendant, the Supreme Court held that the plaintiff's constitutional right to education at age 18 was breached. However, the Court unanimously noted that the State has no constitutional obligation for future education after age 18. Denham J (at para 212) stated: "[C]onstitutional right to the provision of free primary education existed during childhood and ceased when reaches adulthood which, it is reasonable to construe, commenced at the age of eighteen."

<sup>164</sup> *Ibid.*, Finlay P stated: "The right of bodily integrity as an unspecified constitutional right is clearly established by the decision of the Supreme Court in *Ryan v Attorney General* [1965] IR 294, by which I am bound and which I accept. Even though it was there laid down in the context of a challenge to the constitutional validity of a statute of the Oireachtas which, it was alleged, forced an individual to use water containing an additive hazardous to health, I see no reason why the principle should not also operate to prevent an act or omission of the Executive which, without justification, would expose the health of a person to risk or danger. When the Executive, in exercise of what I take to be its constitutional right and duty, imprisons an individual in pursuance of a lawful warrant of a court, then it seems to me to be a logical extension of the principle laid in *Ryan*'s case that it may not, without justification or necessity, expose the health of that person to risk or danger. To state ... that the Executive has a duty to protect the health of persons held in custody as well as is reasonably possible in all the circumstances of the case seems to me no more than to state in a positive manner the negative proposition which I have accepted. Therefore, I am satisfied that such a proposition is sound in law." In *DF v Garda Commissioner & Ors (No. 3)* [2014] IEHC 213, the plaintiff, who had a condition of autism, was arrested and detained by members of An Garda Síochána following a report by a member of the public that he was seen chasing two women with a large stick or a branch of a tree in the vicinity of the plaintiff's grandfather's house. The plaintiff sued for damages for breach of constitutional rights arising from false imprisonment, assault and battery. The court, among other issues considered was whether the plaintiff's remedies are adequate in tort or constitutional provisions be applied if the remedy in tort is ineffective to protect the plaintiff's dignity and bodily integrity. The court was of the opinion that bodily integrity of the plaintiff would not be adequately protected under tort considering the plaintiff's particular circumstances. Hogan J (at para 65) concluded: "[I]n the case of the claims based on a breach of Article 40.3.2 in respect of the protection of the person and ... in respect of the unenumerated bodily integrity under Article 40.3.1 ... the plaintiff will be able to demonstrate ... that these nominate torts of assault and battery will insufficiently vindicate these constitutional rights to the integrity of the person so far as the manner of his arrest by members of the Gardai are concerned, particularly having regard to the requirement that the tort of assault requires a prior apprehension of a battery before it actually takes place, which, having regard to the plaintiff's mental condition, he might not be able to satisfy." (Hogan J's view in the text admitted that the right to person in Article 40.3.2 extends to protecting right to dignity and mental tranquillity and bodily integrity).

right to health are two distinct, albeit overlapping, rights. It is clear that the right to bodily integrity may be breached in some cases where the right to health is not – as, for example, where a doctor carries out a therapeutic intervention without the consent of the patient. It is harder to envisage cases where the right to health is breached without there being a corresponding breach of the right to bodily integrity. Perhaps cases where the breach is related to mental health are examples, as such a breach does not necessarily involve also a breach of the right to bodily integrity.<sup>165</sup>

In considering how courts can best adjudicate upon a constitutionally recognised right to health, it is useful to examine the rich jurisprudence of the Constitutional Court of South Africa which has treated socio-economic rights as justiciable and enforceable as a constitutional obligation against the state.<sup>166</sup> In South Africa, there is an express and unambiguous constitutional recognition of socio-economic rights including, the right to health.<sup>167</sup> In *Soobramoney v Minister of Health (Kwazulu-Natal)*,<sup>168</sup> the plaintiff was suffering from chronic renal failure and his condition

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<sup>165</sup> William Binchy, *Forum on Fluoridation: The Legal Dimension* (2002) Appendix 16, 199. The author states (at 212) that: “As we have seen from the discussion of the right to bodily integrity, the courts, even from the start, have conflated the separate rights of bodily integrity and health. They are, however, logically distinct. One can easily envisage cases of infringement of the former right which do not involve any infringement of the latter, but not the former, right. Perhaps cases involving psychiatric injury could be regarded as coming within this category but there is a respectable school of thought which would classify such an injury as corporeal in character.”

<sup>166</sup> William Binchy, *Constitutionality, the Rule of Law and Socio-Economic Development* (6-9 August 2009 Kasane, Botswana), Southern African Chief Justices Forum (at p. 17-18) remarks: “South Africa’s political and constitutional history has distinctive aspects which raise the question whether it is possible or desirable to generalise from South Africa’s unique experience so as to propose an approach to constitutional interpretation for courts in other countries with a different history and a differently shaped constitution. South Africa’s Constitution has features that are not widely replicated in Southern Africa or elsewhere in the continent. Its jurisprudence on the justiciability of economic and social rights, for example, cannot easily be transposed in view of the specific provisions of its Constitution which find no direct counterpart elsewhere. ... [T]he two key concepts of human dignity and equality, which have generated a rich jurisprudence in South Africa, have sufficient normative force and cultural acceptance throughout Africa to act as strong reference points for the interpretation of constitutions throughout the continent.”

<sup>167</sup> Constitution of South Africa (1996): Chapter II, Section 27. “**Health care, food, water and social security** – (1) Everyone has the right to have access to: (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.”

<sup>168</sup> [1997] ZACC 17.

was irreversible, sought dialysis treatment from a state hospital in Durban. The hospital had been forced to adopt a set of guidelines for dialysis treatment because of its limited facilities. Only those who could be treated through dialysis had automatic access to the treatment.

The plaintiff, having exhausted his funds in a private hospital, brought a claim against the state for free treatment and relied on the provisions of the 1996 Constitution, particularly sections 27(3) and 11 respectively<sup>169</sup>.

In examining the plaintiff's asserted right to emergency treatment, the Constitutional Court found that the plaintiff's situation fell outside of what section 27(3) required, which envisaged circumstances in which an emergency suddenly arose; the patient had no opportunity of making arrangements in advance for the treatment that was required, there was urgency in securing the treatment in order to stabilise his condition, and the treatment was available. The denial of treatment in such circumstances would constitute a breach of section 27(3). By way of contrast, the plaintiff's condition was not an emergency which called for immediate remedial treatment but, rather, was an ongoing state of affairs resulting from a deterioration of his renal function which was incurable<sup>170</sup>.

In consideration of the second limb of the claim, the Constitutional Court found that the plaintiff's demand to receive dialysis treatment had to be determined under the provisions of sections 27(1) and (2).

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<sup>169</sup> Section 27(3) states: No one may be refused emergency medical treatment. Section 11 states: Everyone has the right to life.

<sup>170</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, at para 21. Sachs J (at para 51), stated: "The special attention given by section 27(3) to non-refusal of emergency medical treatment relates to the particular sense of shock to our notions of human solidarity occasioned by the turning away from hospital of people battered and bleeding or of those who fall victim to sudden and unexpected collapse. It provides reassurance to all members of society that accident and emergency departments will be available to deal with the unforeseeable catastrophes which could befall any person, anywhere and at any time."

The Constitutional Court noted the hospital's policy on the management of limited resources regarding rationing for renal dialysis<sup>171</sup> and also acknowledged the reasonableness of the health policy decision of the state hospital of prioritising healthcare needs for treatment in favour of patients who require medical care to cure their ailments<sup>172</sup> over those who suffer terminal illnesses in order to curtail the health budget from overspending beyond the available resources. In view of this, the Constitutional Court affirmed the decision of the trial court that the defendant had proved that there was no fund available to provide patients such as the plaintiff with the necessary treatment on the basis of availability of resources<sup>173</sup>. Chaskalson P concluded:

*“[T]he state’s resources are limited and the plaintiff does not meet the criteria for admission to the renal dialysis programme. Unfortunately, this is true not only of the plaintiff but of many others who need access to renal dialysis units or to other health services. There are also those who need access to housing, food and water, employment opportunities, and social security. ... The state has to manage its limited resources in order to address all these claims. There will be*

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<sup>171</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, at para 52, Sachs J, stated: “... the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.”

<sup>172</sup> *Ibid.*, at para 25, Chaskalson P, stated: “By using the available dialysis machines in accordance with the guidelines more patients are beneficial than would be the case if they were used to keep alive persons with chronic renal failure, and the outcome of the treatment is also likely to be more beneficial because it is directed to curing patients, and not simply to maintaining them in a chronically ill condition. It has not been suggested that these guidelines are unreasonable or that they were not applied fairly and rationally when the decision was taken by the [defendant] that the plaintiff did not qualify for dialysis.”

<sup>173</sup> *Ibid.*, at para 29-30, Chaskalson P stated: “The provincial administration which is responsible for health services ... has to make decisions about the funding that should be made available for health care and how such funds should be spent. These choices involve difficult decisions to be taken at the political level in fixing the health budget, and at the functional level in deciding upon the priorities to be met. A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters. ... [T]he danger of making any order that the resources be used for a particular patient, which might have the effect of denying those resources to other patients to whom they might more advantageously be devoted.”

*times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society.*"<sup>174</sup>

The Constitutional Court premised its decision on a reasonable standard test having regard to utilitarian approach over the individual rights and held that the plaintiff's case must fail, because the State had a sensible, rational and fair system in place for accessing dialysis machines. If the plaintiff went to the top of the queue, he would be displacing a person who would obtain greater benefits from the machine. However, it was the view of the Court that the state has constitutional obligations to provide its citizens with socio-economic rights<sup>175</sup>. Sachs J, concurring in the judgment, stated:

*"The values protected by section 27(3) would ... be undermined rather reinforced by any unwarranted conflation of emergency and non-emergency treatment ... In all the open and democratic societies based upon dignity, freedom and equality ... the rationing of access to life-*

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<sup>174</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, at para 31.

<sup>175</sup> *Ibid.*, at para 36. Cf the decision of the New Zealand Court of Appeal in a similar case which concerned the resource allocation in the management of a terminally ill patient in *Shortland v Northland Health Ltd* [1998] 1 NZLR 433 (CA). The plaintiff suffered from dementia and had a long history of Type 2 diabetes was admitted and placed on interim dialysis to enable assessment of his suitability for acceptance to the hospital's renal replacement programme – specifically his suitability for long-term, home-based peritoneal dialysis (CAPD). In the analysis of the medical team on the guideline for entry to the programme developed by the regional health authority responsible for funding the treatment considered the plaintiff unsuitable for entry onto the programme due to his dementia, which they considered that continued dialysis would extend his life by about a year. The plaintiff alleged that the refusal to provide dialysis amounted to breach of duty to provide the necessities of life; that withdrawing and withholding of dialysis constituted a breach not to be deprived of life in s. 8 of the New Zealand Bill of Rights Act. The Court of Appeal rejected the plaintiff's claim and held that the extent of a duty to provide the necessities of life must be assessed along those responsible for the patient's care ... ultimately ... must decide what in clinical terms and within available resources is best for their patient. Joanna Manning, "Litigating a Right to Health Care in New Zealand", Chapter 1 of C Flood & A Gross eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014) 19, at 40, remarks: "The guidelines were an explicit rationing tool, premised on demand for the treatment exceeding supply, aimed at making fairer, more consistent, and transparent allocation decisions as between patients who could derive varying levels of benefits from treatment. Ironically, the clinical decision was reached by applying an explicit rationing tool, but the Court's decision fell back on the discredited practice of implicit rationing, obscuring a denial of care based on a resource allocation decision (where life itself was at stake) as a clinical judgment about the patient's best interests."



*prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to health care.*<sup>176</sup>

*Minister of Health v Treatment Action Campaign (No. 2)*,<sup>177</sup> concerned the government policy on the restriction of availability of nevirapine which prevents mother-to-child transmission of HIV/AIDS to a designated research and training sites rather than the public health sector. The plaintiffs argued that the restrictions are unreasonable having regard to the constitutional provisions which guarantees access to public healthcare and the right of children to special protection. As a result, the obligations imposed upon the state fell short of its constitutional provisions of sections 27(1) and 28(1)(c) of the 1996 South African Constitution<sup>178</sup>. The defendant argued that inadequate resources due to budgetary constraints prevented the government from carrying out research and training in providing a comprehensive programme using nevirapine for the prevention of mother-to-child transmission.

The Constitutional Court in its analysis of enforcement of socio-economic rights declined to adopt a minimum core content approach articulated by the plaintiffs that the defendants had an obligation to implement and set out clear timeframes for a national programme to prevent mother-to-child transmission of HIV<sup>179</sup>. The Court

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<sup>176</sup> *Soobramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, at para 51-52.

<sup>177</sup> [2002] ZACC 15 (Constitutional Court, South Africa).

<sup>178</sup> Section 27 provides: “(1) Every one has the right to have access to – (a) health care services, including reproductive health care; ... (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment. Section (28)(1) provides: “Every child has the right - ... (c) to basic nutrition, shelter, basic health care services and social services”

<sup>179</sup> *Minister of Health v Treatment Action Campaign (No. 2)* [2002] ZACC 15 (Constitutional Court, South Africa), at paras 34-39, remarked: “[T]he socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated as possibly being relevant to reasonableness under section 26(2), and not as a self-standing right conferred on everyone under section 26(1). A purposive reading of sections 26 and 27 does not lead to any other conclusion. It is impossible to give everyone access even to a ‘core’ service immediately. All that is possible, and all that can be expected of the state, is that it act reasonably to provide access to the socio-economic rights identified in sections 26 and 27 on a progressive basis. ... Courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic

in consideration of whether the defendants were entitled to make nevirapine available to pregnant women who had HIV and who gave birth in the public health sector observed that, although research and training provided a comprehensive framework for mother-to-child transmission to be developed, this did not mean that, until the best programme had been formulated and the necessary funds and infrastructure provided for the implementation of that programme, nevirapine must not be withheld from mothers and children who did not have access to the research and training sites. Nor could it reasonably be withheld until medical research had been completed<sup>180</sup>. In reaching this conclusion, the Court noted that the restrictions of nevirapine to training sites would invariably exclude those who would have been reasonably benefited in the exercise. The Court held:

*“[I]t was not reasonable to restrict the use of nevirapine to the research and training sites, the policy as a whole will have to be reviewed. Hospitals and clinics that have testing and counselling facilities should be able to prescribe nevirapine where that is medically indicated. The training of counsellors ought now to include training for counselling on the use of nevirapine. ... this is not a complex task and it should not be difficult to equip existing counsellors with necessary additional knowledge. In addition, government will need to take reasonable measures to extend the testing and counselling*

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consequences for the community. The Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance. We therefore conclude that section 27(1) of the Constitution does not give rise to a self-standing and independent positive right enforceable irrespective of the considerations mentioned in section 27(2). Sections 27(1) and 27(2) must be read together as defining the scope of the positive rights that everyone has and the corresponding obligations on the state to ‘respect, protect, promote and fulfil’ such rights. The rights conferred by sections 26(1) and 27(1) are to have ‘access’ to the services that the state is obliged to provide in terms of sections 26(2) and 27(2).”

<sup>180</sup> *Ibid.*, at para 68.

*facilities to hospitals and clinics throughout the public health sector beyond the test sites to facilitate and expedite the use of nevirapine for the purpose of reducing the risk of mother-to-child transmission of HIV.*”<sup>181</sup>

It is clear from the *Soobramoney* case that the Constitutional Court of South Africa is reluctant to intervene on the question of resource allocation which involves rationing of scarce resources where there is in place a rationally and normatively defensible system of allocation.<sup>182</sup>

The South African Constitutional Court further reiterated its rejection of minimum core content of the right to water in favour of reasonableness of the free basic water policy in *Mazibuko & Ors v City of Johannesburg & Ors*.<sup>183</sup> The plaintiffs lived in separate households, alleged the defendants which provide water services to the residents of the community of insufficient water supply. The question for determination by the Constitutional Court concerned two issues: first, whether the defendants’ policy in relation to the supply of free basic water and, particularly, its decision to supply 6 kilolitres of free water per month to every accountholder in the

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<sup>181</sup> *Minister of Health v Treatment Action Campaign (No.2)* [2002] ZACC 15, at para 95.

<sup>182</sup> Naomi Njuguna, *Central and College Based Sensitisation of Rapid Results Initiative (RRI) on Constitutional Implementation and Public Service Integrity Programme*, a paper presented at the public lecture on 26 September 2013 at the College of Health Sciences, University of Nairobi, states, “The challenge with socio-economic rights is that resources within the State (whether in developing or developed countries) are scarce. This means that rationing will be involved. As was observed in the *Soobramoney* case (South African case): ‘The exercise of a right that by its nature is shared, often competitively, with other holders of this rights, must have different legal characteristics from the exercise of a classical individual civil right that is autonomous and complete in itself.’ – This means that the right to health, for example, is not the same as the right to vote. When a person votes, he does not affect the right of another person to vote or even how he is to vote. But when a mother receives free maternity services from a government hospital or if a person were to receive free dialysis treatment, then the cost of providing that treatment is taking away financial resources from another socio-economic right, eg education, or even another person who also needs treatment in the same or other government health facility. The judicial enforcement of socio-economic rights which includes the right to health then becomes a very tall order indeed.”

<sup>183</sup> [2009] ZACC 28.

city was in conflict with s. 27(1)(b)<sup>184</sup> of the Constitution, and, secondly, whether the installation of pre-paid water meters by the defendants was lawful.

The courts below had quantified the amount of water needed per person in a day<sup>185</sup> and had held that the free basic water policy was accordingly unreasonable.

The Constitutional Court did not agree, taking the view that such specificity was inconsistent with the Constitution's broad requirement that the legislative measures should be "reasonable". The legislature was better able, in the first place, to make this assessment, in the light of available resources<sup>186</sup>. However, the Court acknowledged that the positive obligations imposed on the government by constitutional provisions to assess the reasonableness of the steps taken<sup>187</sup> in the context of social and economic rights would be enforced by the court where the question properly arose. O'Regan J stated:

*“[T]he positive obligations imposed upon government by the social*

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<sup>184</sup> 1996 Constitution: “Everyone has the right to have access to – sufficient food and water. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.”

<sup>185</sup> Linda Stewart, *Adjudicating Socio-Economic Rights Under a Transformative Constitution* (2010) 28 Penn State International L Rev 487, at 501, remarks: “I am ... of the opinion that both courts went too far in their effort to provide normative clarity to this specific right by prescribing a specific quantified amount of water per person per day to which a person is entitled instead of using a broader universal standard based on the values in the Constitution. The danger of this approach lies in the possibility that it may be unattainable for government to implement the order made by the Court which will automatically bring the credibility of the Court in the transformation of society into disrepute.”

<sup>186</sup> *Mazibuko & Ors v City of Johannesburg & Ors* [2009] ZACC 28, at para 59-60, O'Regan J, stated: “[W]hat the right requires will vary over time and context. Fixing a quantified content might, in a rigid and counter-productive manner, prevent an analysis of context. The concept of reasonableness places context at the centre of the enquiry and permits an assessment of context to determine whether a government programme is indeed reasonable. ... ordinarily it is institutionally inappropriate for a court to determine precisely what the achievement of any particular social and economic right entails and what steps government should take to ensure the progressive realisation of the right. This is a matter, in the first place, for the legislature and executive, the institutions of government best placed to investigate social conditions in the light of available budgets and to determine what targets are available in relation to social and economic rights. Indeed, it is desirable as a matter of democratic accountability that they should do so for it is their programmes and promises that are subjected to democratic popular choice.”

<sup>187</sup> *Mazibuko & Ors v City of Johannesburg & Ors* [2009] ZACC 28, at para 66, O'Regan J explained the procedural constitutional obligation, stated: “The Constitution envisages that legislative and other measures will be the primary instrument for the achievement of social and economic rights. Thus it places a positive obligation upon the state to respond to the basic social and economic needs of the people by adopting reasonable legislative and other measures, the rights set out in the Constitution acquire content, and that content is subject to the constitutional standard of reasonableness.”

*and economic rights in our Constitution will be enforced by courts in at least the following ways. If government takes no steps to realise the rights, the courts will require government to take steps. If government's adopted measures are unreasonable, the courts will similarly require that they be reviewed so as to meet the constitutional standard of reasonableness. From **Grootboom**, it is clear that a measure will be unreasonable if it makes no provision for those most desperately in need. If government adopts a policy with unreasonable limitations or exclusions, as in **Treatment Action Campaign (No. 2)**, the Court may order that those are removed. Finally, the obligation of progressive realisation imposes a duty upon government continually to review its policies to ensure that the achievement of the right is progressively realised.*"<sup>188</sup>

The Court concluded that the defendants' policy of water rationing was fair enough, having considered its obligations of taken reasonable measures progressively to achieve the right of access to sufficient water<sup>189</sup>.

The decision of the Constitutional Court in *Mazibuko's* case elicited criticism<sup>190</sup> among commentators<sup>191</sup> and several activists in the area of socio-economic

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<sup>188</sup> *Mazibuko & Ors v City of Johannesburg & Ors* [2009] ZACC 28, at para 67.

<sup>189</sup> *Ibid.*, at para 168.

<sup>190</sup> See Linda Jansen van Rensburg, *The Right of Access To Adequate Water [Discussion of Mazibuko v The City of Johannesburg Case No. 13865/06]* (2008) 19 Stellenbosch Law Review 415; Dugard & Liebenberg, *Muddying the waters: The Supreme Court of Appeal's Judgment in the Mazibuko case* (2009) 10 Economic and Social Rts Rev 11; Louis Kotze, *Phiri, the plight of the poor and the perils of climate change: Time to rethink environmental and socio-economic rights in South Africa?* (2010) 1 J of Human Rts and the Environment 135; Linda Stewart, *Adjudicating Socio-Economic Rights Under a Transformative Constitution* (2010) 28 Penn State International L Rev 487.

<sup>191</sup> Murray Wesson, *Reasonableness in Retreat? The Judgment of the South African Court in Mazibuko v City of Johannesburg* (2011) Human Rts L Rev 1, at 2, the author remarks in introduction: "[T]he Court's judgment in *Mazibuko* is marked by a high level of deference, especially in respect of the compatibility of the challenge policy with municipal by-laws and national primary legislation and in its application of the constitutional equality right. That said, there are factors that differentiate *Mazibuko* from the Court's earlier decisions, such as the fact that the complainants had not been excluded or overlooked by the relevant social programme. These factors do not justify the

rights,<sup>192</sup> who considered that the Court's rejection of the minimum core doctrine was a denial of basic entitlements of the most deprived members of society.<sup>193</sup>

A strikingly similar approach to that adopted by the South African Constitutional Court in *Soobramoney* is apparent in a number of other African countries. In *Mathew Okwanda v Minister of Health and Medical Services*,<sup>194</sup> the plaintiff, suffering from diabetes, sought free medical treatment under Article 43 of 2010 Constitution of Kenya<sup>195</sup>. Two issues fell for determination. The first was whether the court could make an order compelling the state to provide citizens with

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level of deference applied in *Mazibuko*, but they do suggest that the implications of the judgment for the future enforcement of socio-economic rights by the Constitutional Court should not be overstated.”

<sup>192</sup> Oliver Njuh Fuo, *The Right of Access to Sufficient Water in South Africa: Comments on Federation for Sustainable Environment and Others v Minister of Water Affairs* [2012] ZAGPPHC 128 (2013) 20 Murdoch University L Rev 21, at 23-24, the author refers: “The decision of the court in the *Mazibuko* case has been criticised by academics for a number of reasons. Firstly, writers have expressed disappointment with the fact that, although the Court recognised the importance of water to the realisation of other rights in the Bill of Rights, it failed to give normative content to the right of access to sufficient water in South Africa. Secondly, the Court has also been criticised for focussing on the meaning of the right to access and quantity of water sufficient for purposes of s. 27(1)(b) of the Constitution, without sufficient attention to the quality of water. Thirdly, it has been argued that the Court diluted the standard of reasonableness established in its earlier socio-economic rights jurisprudence. In addition, the Court has been criticised for failing to take into consideration the historical context of water challenges in South Africa and the fact that the country is semi-arid and suffering from water scarcity. Moreover, its analysis failed to integrate environmental considerations and the implications thereof for access to water in South Africa. In addition to criticisms directed at the Court, concerns have been raised about the general indifference towards the plight of the poor, who suffer from the privatization and commercialization of water services.”

<sup>193</sup> Jackie Dugard, *Judging the Judges: Towards an Appropriate Role for the Judiciary in South Africa's Transformation* (2007) 20 Leiden J of Int'l L 965, at 973, observes: “[T]he Court has interpreted SER in an overly cautious way that has provided few incentives to poor litigants to seek relief through constitutional litigation. Instead of robustly clarifying the content of SER and vigorously monitoring government performance to ascertain whether all obligations (negative and positive) have been adequately discharged or whether there have been violations to the core content of rights, the Court has chosen a diluted, and quite abstract, measure: inquiring into the reasonableness of programmes in the context of the availability of the state's resources. This standard of review – namely that the overall policy, legislation, and practices of government should be reasonable – ‘requires litigants to have a sophisticated understanding of often complex policy and budgetary issues’, which ‘acts as a disincentive to the poor to bring cases to the Court, unless they have substantial legal and other expert support’. The Court's tentative approach to SER adjudication is also reflected in its remedies.” See also Elizabeth Larson, *At the intersection of neoliberal development, scarce resources, and human rights: Enforcing the right to water in South Africa* (2010 Honors Thesis, Macalester College), at p 75: “The approach that the Constitutional Court took in the *Mazibuko* case, coupled with the overarching circumstances in South Africa, has consequences for the justiciability of right to water. One of the main reasons that the Constitutional Court cites for rejecting the minimum core approach to socio-economic rights is that it would interfere with the budget. The Court shies away from decisions that would influence the macro-economic policy of the state, and the water infrastructure falls under the umbrella of macroeconomic policy. ... South Africa's water policy is influenced by its larger neoliberal economic strategy. This neoliberal economic strategy was adopted under the pressure of globalization, and has not succeeded in improving the conditions of those living in poverty or in the delivery of water infrastructure to all citizens.”

<sup>194</sup> [2013] eKLR.

<sup>195</sup> Article 21(2) provides that: The State shall take legislative, policy and other measures including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43.

adequate and highest attainable standards of health, housing, social security and reasonable standards of sanitation as espoused under Article 11 of the ICESCR, and Articles 2(5), 6 and 43 of the Constitution of Kenya, 2010. The second was whether the plaintiff had established that the state had failed in its obligation to observe, respect, promote and fulfil the rights and fundamental freedoms in the Bill of Rights.

The view of the court was that it could not enforce a policy decision, vindication of socio-economic rights remained the function of the executive but the court would enforce its compliance where there was a breach of constitutional and statutory standards in delivering its obligations to the citizenry. Majanja J stated:

*“It is not unreasonable for the petitioner and other concerned Kenyans to demand that a concrete policy framework be rolled out and implemented to address the containment and treatment of various health afflictions. These, however, are matters of policy which the State is expected to address in light of its clear obligations. In the absence of a focused dispute for resolution by the court, I am reluctant to express myself on the broad matters raised in the submissions unless there is sufficient material that there has been a violation of the Constitution and the court is required to act to provide the requisite relief.”<sup>196</sup>*

Similarly in the more recent case of *Luco Njagi & Ors v Ministry of Health & Ors*,<sup>197</sup> the High Court of Kenya rejected the petitioners’ claim who alleged that their right to health had been infringed as a result of inadequate renal dialysis

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<sup>196</sup> *Mathew Okwanda v Minister of Health and Medical Services* [2013] eKLR, at para 24.

<sup>197</sup> [2015] eKLR.

equipment or repairing the few existing ones to meet their demands. They sought a declaration that the defendants be directed to pay hospital bills on their behalf where each was receiving dialysis treatment at private hospitals or, alternatively, to subsidise the cost at the rate which the petitioners would have accessed treatment at public hospital. The defendants denied violation of their constitutional right to health and argued that socio-economic rights are subject to progressive realization upon the State within its resources. The court held that it was required to balance the interest of parties involved in the light of the resources available to the defendants. The court applied the South African Constitutional Court decision in the *Soobramney* case that the defendants were best placed to decide whether those who were chronically ill or the in-patients with acute renal failure should be given priority in the provision of dialysis treatment, holding that the right to health of the petitioners had not been violated. Ngugi J concluded:

*“[I]n my view, for the court to attempt to tell the state that it must have a certain number of dialysis machines at a certain period in time or that it must ensure access to these machines in private institution when the court cannot determine the availability of resources, or what impact the diversion of resources to meet the petitioners’ individual demands would have. I say this while appreciating the dearth of information supplied by the parties, ... in relation to its policies and budgets for health vis-à-vis other sectors, but bearing in mind also the limitations of the court in making a determination on what is appropriate expenditure in the various sectors for which the state is responsible.”<sup>198</sup>*

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<sup>198</sup> *Luco Njagi & Ors v Ministry of Health & Ors* [2015] eKLR, at para 88.



In a public interest suit in *Kenya Society for the Mentally Handicapped v Attorney-General*,<sup>199</sup> the petitioners alleged that the defendants had violated the socio-economic rights of persons with mental and intellectual disability by discriminating against them in the provision of support and services. The claim failed on the ground that it was too general in its remit. The petitioners had failed to identify the specific policies that ran contrary to the constitutional provisions<sup>200</sup>. Manjaja J stated:

*“The Court’s purpose is not to prescribe certain policies but to ensure that policies followed by the State meet constitutional standards and that the State meets its responsibilities to take measures to observe, respect, promote, protect and fulfil fundamental rights and freedoms and a party who comes before the Court.”*<sup>201</sup>

In *Patricia Asero Ochieng v The Attorney-General*,<sup>202</sup> the petitioners, all living with HIV/AIDS, sought declarations that their fundamental rights under sections 70 and 71 of the Kenyan Constitution were likely to be infringed by the implementation of Kenya’s Anti Counterfeit Act 2008, which limited their access to affordable and essential drugs, including generic medicines, for HIV/AIDS and that its enforcement would infringe their right to life, human dignity and health. The High Court, Nairobi had no hesitation in giving priority to these rights over intellectual property rights<sup>203</sup>. It acknowledged the right to health of the petitioners

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<sup>199</sup> [2012] eKLR.

<sup>200</sup> *Ibid.*, at para 18, Manjaja J stated: “I think the petitioners have brought this case to address the whole spectrum of issues concerning persons with disabilities. . . ., the petitioners have dealt with the right to education, the right to health, the right to employment, access to justice, the right to justice and political rights.”

<sup>201</sup> *Ibid.*

<sup>202</sup> [2012] eKLR.

<sup>203</sup> *Patricia Asero Ochieng v The Attorney-General* [2012] eKLR, at para 85-86, Ngugi J stated: “The right to life, dignity and health of the petitioners must take precedence over the intellectual property rights of patent holders.

as well as a corresponding positive obligation resting on the State in regard to the right of its citizens have access to the highest attainable standard of health<sup>204</sup>. Ngugi J, identifying a difference between generic and counterfeit medicine, stated:

*“In my view, the definition of 'counterfeit' in section 2 of the Act is likely to be read as including generic medication. I would therefore agree with the Amicus that the definition 'would encompass generic medicines in Kenya and elsewhere and thus is likely to adversely affect the manufacture, sale, and distribution of generic equivalents of patented drugs. This would affect the availability of the generic drugs and thus pose a real treat to the petitioners' right to life, dignity and health under the Constitution'.”*<sup>205</sup>

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While such intellectual property rights should be protected, there is the likelihood, as in this case, that their protection will put in jeopardy fundamental rights such as the right to life of others, I take the view that they must give way to the fundamental rights of citizens in the position of petitioners.”

<sup>204</sup> *Ibid.*, at para 66, Ngugi J stated: “The state’s obligation with regard to the right to health therefore encompasses not only the positive duty to ensure that its citizens have access to health care services and medication but must also encompass the negative duty not to do anything that would in any way affect access to such health care services and essential medicines. Any legislation that would render the cost of essential drugs unaffordable to citizens would thus be in violation of the state’s obligations under the constitution.”

<sup>205</sup> *Ibid.*, at para 78. The intention of parallel importation of generic drugs by the government affords the public to have access to essential drugs at affordable price. In *Pharmaceutical Manufacturers Association of South Africa (PMA) v Government of the Republic of South Africa* [2000] ZACC 1. The plaintiffs sought for a declaration to the proposed amendments to the Medicines and Related Substances Act 1965 as null and void. The South Africa Constitutional Court noted: “The applicants acted promptly in coming to court and there is nothing to suggest that any legitimate interest of any member of the public has been prejudiced by the order made by the Full Bench. On the contrary, a failure to confirm the order would have serious consequences for the control of medicines and could invalidate actions taken to that end in terms of the Act since the order was made.” The Supreme Court of Philippines considered the importation of the similarly branded medicine in *Del Rosario & Ors v Bengzona & Anor* (G.R. No. 88265, 21 December 1989). The plaintiffs alleged unequal treatment of government physicians and those in private practice in the manner of prescribing generic drugs, urged the Court to declare as unconstitutional some sections of the Generic Act 1988. The Supreme Court weighed the benefits of generic drugs in favour of public interest that it will be beneficial to patients by making the drugs available at a lower price, thus rejected the argument of the plaintiffs. It took the view that the Court has not found any constitutional infirmity in the Generic Act other than “to protect and promote the right to health of the people” and “to make essential goods, health and other social services available to all the people *at affordable cost*”. Grino-Aquino J stated: “The prohibition against the use by doctors of ‘no substitution’ and/or words of similar import in their prescription, is a valid regulation to prevent the circumvention of the law. It secures to the patient the right to choose between the brand name and its generic equivalent since his doctor is allowed to write both the generic and the brand name in his prescription form. If a doctor is allowed to prescribe a brand-name drug with ‘no substitution’, the patient’s opinion to buy a lower-priced, but equally effective, generic equivalent would thereby be curtailed. The law aims to benefit the impoverished (and

It is apparent from the decision in this case that the right to health involves a derivative right of access to essential medicines.<sup>206</sup> The Court called on the State parties to prevent impediments to such access and to make such medicines available and affordable at both public and private healthcare facilities.<sup>207</sup>

In the Ugandan case of *Centre for Health, Human Rights & Development v Attorney-General*,<sup>208</sup> the Constitutional Court summarily struck out the petitioners' claims without considering its merits on the basis that it raised a "political question". The petitioners alleged non-provision of basic indispensable maternal health elements in the defendant's health facilities and the imprudent and unethical attitude of health workers towards expectant mothers constituted acts and omissions were in violation of the Directive Principles and inconsistent with the Constitution. The defendant contended that the petitioners' claims suggested a

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often sickly) majority of the population in a still developing countries like ours, not the affluent and generally healthy minority."

<sup>206</sup> Stephen P. Marks, *Access To Essential Medicines As A Component Of The Right To Health* (2009) Health: A Human Rights Perspective 82, at 82, observes: "As a component of the right to health, the right to essential medicines depends not only on the production, distribution, and pricing of medicines, but also on the incentives for research and development of drugs needed to treat diseases ..."

<sup>207</sup> General Comment No.17 (2005): The right of everyone to benefit from the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he or she is the author (article 15, paragraph 1(c), of the Covenant). Related obligations – (at para 35): The right of authors to benefit from the protection of the moral and material interests resulting from their scientific, literary and artistic productions cannot be isolated from the other rights recognized in the Covenant. State parties are therefore obliged to strike an adequate balance between their obligations under article 15, paragraph 1(c), on one hand, and under the other provisions of the Covenant, on the other hand, with a view to promoting and protecting the full range of rights guaranteed in the Covenant. In striking this balance, the private interests resulting from one's scientific, literary or artistic productions constitute no impediment to their ability to comply with their core obligations in relation to the rights to food, health and education, as well as to take part in cultural life and to enjoy the benefits of scientific progress and its applications, or any other right enshrined in the Covenant. [27] Ultimately, intellectual property is a social product and has a social function. [28] States parties thus have a duty to prevent unreasonably high costs for access to essential medicines, plant seeds or other means of food production, or for schoolbooks and learning materials, from undermining the rights of large segments of the population to health, food and education. Moreover, States parties should prevent the use of scientific and technical progress for purposes contrary to human rights and dignity, including the rights to life, health and privacy, eg by excluding inventions from patentability whenever their commercialization would jeopardize the full realization of these rights. [29] States parties should, in particular, consider to what extent the patenting of the human body and its part would affect their obligations under the Covenant or under other relevant international human rights instruments. [30] States parties should also consider undertaking human rights impact assessments prior to the adoption and after a period of implementation of legislation for the protection of the moral and material interests resulting from one's scientific, literary or artistic productions.

<sup>208</sup> 30 October 2015.

judicial decision involving political questions will no doubt amount to an interference with the functions of the legislature and the executives.

The Constitutional Court held that “the issue raised by the petitioners concern the manner in which the Executive and the Legislature conduct public/issuances, affairs which is their discretion and not for this court. This court is bound to leave certain constitutional questions of a political nature to the Executive and the Legislature to determine”.

The Supreme Court reversed. Kisaakye JSC considered that:

*“the political question doctrine has limited application in Uganda’s current Constitutional order and only extends to shield both the Executive arm of Government as well Parliament from judicial scrutiny where either institution is properly exercising its mandate, duty vested in it by the Constitution. It goes without saying that even in these circumstances, factual disputes will always come up where a private citizen challenges either the Executive or Parliament action or inaction and the resultant outcome of such actions and inaction in respect to either institution’s implementation of its respective constitutional mandate and whether such action or inaction contravenes or is inconsistent with any provision of the Constitution. It is my considered view that it was for this very purpose that the Constitutional Court was established and given powers under Article 137(1) and (3) to consider these allegations and determine them one way or another.”*

It is clear from the petitioners' claims, as noted in the separate judgment of Katureebe CJ, that the petition alleged negligence which, being a tort, can be decided by the High Court without the need for the petitioners to have recourse to the Constitutional Court.

In an earlier case, the High Court of Uganda, had held the view that the right to healthcare is justiciable in the context of access to emergency obstetric care. In *Centre for Health, Human Rights and Development & Ors v Nakaseke District Local Administration*,<sup>209</sup> the plaintiffs brought an action in respect of the death of the deceased, who had labour pains and was taken to the defendant's hospital by her husband for delivery. The attending nurse discovered that the deceased had obstructed labour, requiring the intervention of doctor on duty, whom she called four times but who failed to respond until after about eight hours when it was already too late for any medical intervention to save the deceased, who died of a haemorrhage arising from a ruptured uterus.

The court held that the evidence had revealed that the defendant had denied the deceased her entitlement to receive the obstetric care to which she was entitled under the Constitution<sup>210</sup>, and that "the human and maternal rights of the deceased and the rights of the children and spouse, arising under the Constitution, were violated".<sup>211</sup>

The court did not find the defendant liable for negligence as this had not been specifically pleaded in the plaintiffs' claim. In consequence, the court declined to award punitive damages for the violation of the plaintiffs' constitutional rights

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<sup>209</sup> 17 June 2015 (HC).

<sup>210</sup> 1995, Article 33(3) provides: The State shall protect women and their rights, taking into account their unique status and natural maternal functions in society.

<sup>211</sup> Contrast with the Irish case in *P. H. & Ors (Infant) v John Murphy & Sons Ltd* [1987] IR 621 (HC).

having regard to the demands on the defendant's limited resources. Kabiito J observed:

*“The defendant being [a] local district council has means and resources that go principally toward the operations and management of the defendant. I must take judicial notice that such means and resources, are often in short supply and barely adequate to cover the intended services. For this reason therefore, I make no award of punitive damages that could affect the operations and management of the defendant.”*<sup>212</sup>

In Ireland, the approach towards justiciability of the right to health is closer to that of the Constitutional Court of Uganda than of the Supreme Court in *Centre for Health, Human Rights & Development v Attorney-General*.<sup>213</sup>

In *Sinnott v Minister for Education*,<sup>214</sup> the first named plaintiff developed normally at birth but after a few months, began to display symptoms of the condition of autism. He alleged discrimination having being denied of his constitutional obligation for primary education. He further alleged a failure on the part of the State to provide education and training appropriate to those affected by autism.

The issues examined by the Supreme Court concerned whether the Constitution confers the right to a life-long free primary education and whether the court has the inherent power to direct the policy or function of the executive in the implementation of socio-economic rights.

The Court in its unanimous decision as regards the first claim rejected the approach that the duty to provide for primary education may extend throughout a person's

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<sup>212</sup> Contrast this approach with the Irish case in *Conway v INTO* [1991] 2 IR 305.

<sup>213</sup> 30 October 2015.

<sup>214</sup> [2001] 2 IR 505.

life into old age<sup>215</sup>. With regard to the second claim, having taking into account the plaintiff's condition and needs in reference to the enforcement of the state's policy, the Court held that the separation of powers doctrine required courts to exercise severe restraint in regard to the socio-economic policy of the Executive<sup>216</sup>. Hardiman J stated:

*“In my view, conflicts of priorities, values, modes of administration or sentiments cannot be avoided or ignored by adopting an agreed or imposed exclusive theory of justice. And if judges were to become involved in such an enterprise, designing the details of policy in individual cases or in general, and ranking some areas of policy in priority to others, they would step beyond their appointed role. The views of aspirants to judicial office on such social and economic questions are not canvassed for the good reason that they are thought to be irrelevant. They have no mandate in these areas. And the legislature and the executive, possessed of a democratic mandate, are liable to recall by the withdrawal of that mandate. This is the most fundamental, but by no means the only, basis of the absolute necessity for judicial restraint in these areas. To abandon this restraint would be unacceptably and I believe unconstitutionally to limit the proper freedom of action of the legislature and the executive branch of*

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<sup>215</sup> *Sinnott v Minister for Education* [2001] 2 IR 505, at para 324.

<sup>216</sup> *Ibid.*, Hardiman J stated (at para 374): “The fact that powers to deal with extreme circumstances must be retained cannot be a basis for the exercise of such powers in any other circumstances. Firstly, to do so would offend the constitutional separation of powers. Secondly, it would lead the Courts into the taking of decisions in areas in which they have no special qualification or experience. Thirdly, it would permit the Courts to take such decisions even though they are not, and cannot be, democratically responsible for them as the legislature and the executive are. Fourthly, the evidence based adversarial procedures of the Court, which are excellently adapted for the administration of commutative justice, are too technical, too expensive, too focused on the individual issue to be an appropriate method for deciding on issues of policy.”

government.”<sup>217</sup>

The experience in India is one of stark contrast to that of Ireland. The Indian Supreme Court in the 1950s took the view that the provisions of Part IV of the Indian Constitution relating to the Directive Principles were not justiciable as a result of Article 37<sup>218</sup>, which provided that the Directives Principles shall not be enforceable by any court<sup>219</sup>. Article 37 had been modelled directly on Article 45 of the Irish Constitution.

The judicial position in India underwent radical change in the 1980s.<sup>220</sup> In *Minerva Mills v Union of India*,<sup>221</sup> the Supreme Court elevated the constitutional status of

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<sup>217</sup> *Sinnott v Minister for Education* [2001] 2 IR 505, at para 377. Cf the decision in *T.D v Minister for Education* [2001] 4 IR 259. There, the plaintiff sought a direction from the defendant to provide for appropriate education suitable for his needs in a suitable educational establishment on account of being emotionally disturbed. In the analysis of the Supreme Court, it held the view that court should be reluctant even to appear to trespass on the spheres of the political organs of government. Hardiman J (at para 364), reaffirmed his earlier decision in *Sinnott's* case, stated: “It was ... acknowledged in my judgment in *Sinnott* that court intervention would be justified if, almost impossible to imagine, the political branches of government were to make any provision for primary education. But it was stressed that a power available to deal with an absolutely extreme situation must not be applied to another less acute.” In conclusion, the Supreme Court held that on the fact of the case, it was evident that enormous efforts had been made at considerable expense to address the needs of the plaintiff.

<sup>218</sup> 1949 Indian Constitution: Article 48A – Directive Principles of State Policy: Application of the principles contained in this Part – The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.

<sup>219</sup> *The State of Madras v Srimathi Champakam* (1951) SCR 525, at 531, the Supreme Court of India stated: “The directive principles of the State policy, which by article 37 are expressly made unenforceable by a Court, cannot override the provisions found in Part III which, notwithstanding other provisions, are expressly made enforceable by appropriate Writs, Orders or directions under article 32. The Chapter of Fundamental Rights is sacrosanct and not liable to be abridged by any Legislative or Executive Act or order, except to the extent provided in the appropriate article in Part III. The directive principles of State policy have to conform to and run as subsidiary to the Chapter of Fundamental Rights. In our opinion, that is the correct way in which the provisions found in Parts III and IV have to be understood. However, so long as there is no infringement of any Fundamental Right, to the extent conferred by the provisions in Part III, there can be no objection to the State acting in accordance with the directive principles set out in Part IV, but subject again to the Legislative and Executive powers and limitations conferred on the State under different provisions of the Constitution.”

<sup>220</sup> Venkat Iyer, “The Supreme Court of India”, Chapter 4 of Brice Dickson ed, *Judicial Activism In Common Law Supreme Courts* (Oxford University Press 2007) 121, the author examine the role of the Supreme Court of India in three stages (1950-1973; 1974-1977, 1978-present) between the executive and legislature as it affects the constitutionality of fundamental rights and public policy under a democratic society in India. The author observes that, during the second stage, judges did not seek to initiate social revolution or justify their actions on the basis of vaguely defined socio-economic theories which were extrinsic to the constitutional settlement. They were concerned, by and large, with issues of jurisdiction and constitutionality, not with the weighing of the values underlying government policy or legislative enactments, much less with tackling ‘structural inequities’. The author (at 137) remarks: “The period between 1973-1977 was easily the least glorious in the annals of the Supreme Court. It was a



the Directive Principles, and the Court began interpreting fundamental rights under Part III in the light of the provisions of Part IV. In the area of environmental protection, the Supreme Court has recognised the right of every Indian to live in a healthy or pollution-free environment by utilising the environmental provisions of Part IV to flesh out the constitutional right to life.<sup>222</sup> In *Consumer Education and Research Centre v Union of India*,<sup>223</sup> the plaintiff initiated public interest litigation regarding occupational health hazards and diseases caused to people employed in asbestos industries, seeking enforcement and interpretation of fundamental right, particularly the right to life and liberty under Article 21 of the 1950 Constitution, read with Articles 39(e), 41, 43, 48A of Directive Principles of State Policy. The Supreme Court of India reiterated the justiciable status of the Directive Principles of State Policy in the Constitution, stating:

*“The Charter of the United Nations thus reinforces the faith in fundamental human rights and in the dignity and worth of the human person envisaged in the Directive Principles of State policy as part of the Constitution.”*<sup>224</sup>

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period when the Court became both highly politicized and significantly marginalized. The two 'supersessions', the petty and open bickering among members of the Court, and the alacrity with which some of the judges allowed themselves to be suborned by Mrs Gandhi's government marked a low point in the Court's dignity and collegiality. It also set the scene for the near capitulation of the Court to the dictates of the emergency regime and for an unprecedented phase of judicial passivity – a phase whose starkest manifestation came in the *habeas corpus* decision of 1976.” The author (at 159) concludes on the third stage that: “The post-emergency activism of the Court has been attributed by many commentators to its keenly-felt sense of falling public credibility. To that extent, it was an exercise in self-legitimation. But the activism was also marked by a high degree of populism, born of a desire on the part of the Court to be seen as less elitist than it had been in the past.”

<sup>221</sup> (1980) AIR 226 (SC), at 252.

<sup>222</sup> Constitution of India (1950): Duty of the State to raise the level of nutrition and the standard of living and to improve public health – Article 47 states: “The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.”

<sup>223</sup> (1995) 3 SCC 42.

<sup>224</sup> *Consumer Education and Research Centre v Union of India* (1995) 3 SCC 42, at para 22. Similarly, the Supreme Court of Ghana in *New Patriotic Party v Attorney-General* [1993-94] 2 GLR 35, the plaintiff sought for a declaration that the public celebration of the coup d'état of 31 December as a statutory public holiday was inconsistent with

The Supreme Court expanded the scope of Article 21 of 1950 Constitution by holding that the right to health is an integral part of a meaningful right to life<sup>225</sup>, making the life of the employee purposeful, with dignity of the person<sup>226</sup>. In *Banga Khet Mazdoor Samity v State of West Bengal*,<sup>227</sup> the Court considered whether denial of emergency medical aid on the ground of inadequate healthcare facilities arising from financial constraints to treat a patient at a government hospital amounts to a violation of constitutional rights. The Court rejected the argument of financial constraints for non-performance of constitutional obligations reposed on the State and concluded:

*“The Health Centres and the hospitals and the medical personnel attached to these Centres and hospitals are geared to deal with [a] larger number of patients needing emergency treatment on account of higher risk of accidents on certain occasions and in certain seasons.”*<sup>228</sup>

Agrawal SCJ stated:

*“It is no doubt true that financial resources are needed for providing these facilities. But at the same time it cannot be ignored that it is the constitutional obligation of the State to provide adequate medical services to the people. Whatever is necessary for this purpose has to*

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articles 3, 35(1) and 41(b) of the 1992 Constitution. The issue for determination before the Supreme Court was whether the Directive Principles of State Policy were justiciable. Adede JSC, in giving the lead judgment stated: “The Directive Principles of State Policy contained in the 1992 Constitution, ... were justiciable because the Constitution as a whole was a justiciable document and accordingly, if any part was non-justiciable, the Constitution itself had to indicate it.”

<sup>225</sup> *Ibid.*, at para 26.

<sup>226</sup> *Ibid.*, at para 27.

<sup>227</sup> (1996) 4 SCC 37.

<sup>228</sup> *Banga Khet Mazdoor Samity v State of West Bengal* (1996) AIR SC 2426, at para 15(7).

*be done.*"<sup>229</sup>

### *The Position in Nigeria*

Let us now turn to consider the position in Nigeria. The Nigerian Constitution entrenches both civil and political rights and socio-economic rights but the right to health is inferred from the right to life under Chapter IV of the 1999 Constitution,<sup>230</sup> while the right to healthcare exists as a socio-economic right under the Directive Principles for the government as opposed to constitutional right,<sup>231</sup>

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<sup>229</sup> *Ibid.*, at para 16.

<sup>230</sup> In a similar development in America, constitutional or statutory right to health is not provided for, let alone healthcare except by insurance scheme on contractual terms. Allison K. Hoffmam, "A Vision of an Emerging Right to Health Care in the United States", Chapter 13 of C Flood & A Gross eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014) 345, at 355-357, remarks: "The America legal structure is one that in general favors negative rights – or liberties – and disfavors positive rights. A primary reason why litigation has not played a major role in defining or guaranteeing a right to health care is because the U.S Constitution has no explicit right to health, nor have the courts read an implicit one. The Supreme Court, as part of its resistance to an expansion of welfare rights more generally, has declined to read a right to health into the substantive due process provision of the Fourteenth Amendment to the Constitution, a provision protecting against deprivations of life, liberty, or property. . . ., Supreme Court decisions have explicitly dismissed a state obligation to pay for a guarantee health care, even to indigent populations – *Harris v McRae* (1980) 448 U.S 297, at 331; *Maher v Roe* (1977) 432 U.S 464, at 469. . . . State constitutions, while gesturing at health care rights textually, similarly do not tend to create any broadly enforceable right to health care in application. According to research by Professor Elizabeth Weeks Leonard, about one-quarter of state constitutions mention the importance of public health and welfare or the responsibility of the state to care for the indigent, insane, or incarcerated, but court interpretation of these provisions has not construed them to confer a right to health care. With no acknowledge positive constitutional right to health (or health care) at the federal or state level, litigants lack an overarching hook for legal claims to a right to health care."

<sup>231</sup> Remigius N. Nwabueze, "The Legal Protection and Enforcement of Health Rights in Nigeria", Chapter 14 of C Flood & A Gross eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014) 371, at 372-373 states the overview of the right to health in Nigeria, that: "Nigeria appreciates the dynamics of the health-development intermix; it also favours a broad conception of health, encompassing both access to health care and services and also the background conditions of good health, such as clean drinking water, sanitation, adequate nutritious food, and a clean environment. Nigeria's Revised National Health Policy recognizes that 'health and access to quality and affordable health care is a human right'. Thus, the Nigerian Constitution provides for a mixed of rights to health and health care services, although such rights as articulated are not justiciable. . . . The National Health Bill 2011 intends to fill enforcement gaps in the protection of health rights. The Bill establishes a National Health System empowered to provide 'for persons living in Nigeria the best possible health services within the limits of available resources' and to 'protect, promote and fulfil the rights of the people of Nigeria to have access to health care services'. This statutory enforcement of the right to health has yet to become law and, even if enacted, is conditional on the availability of resources. Given the absence of a statutory framework for the right to health, the analysis that follows focuses on the relevant constitutional provisions. Given the centrality of health to the development of a country like Nigeria, and the dysfunctional state of health care infrastructure and services in Nigeria, one might expect the panoply of health-related guarantees under the Constitution would spur widespread litigation. Despite the non-justiciability of such rights, as argued in Section 14.3, indirect enforcement is possible through the right-to-life guarantee. However, social mobilization in favour of litigating health rights is lacking. Furthermore, even if a social movement resulted in constitutional or other legal

where the enjoyment of it is largely dependent on the availability of resources,<sup>232</sup> as provided for under s. 17(3)(c) and (d) of the 1999 Constitution<sup>233</sup>.

Nigeria has incorporated the African Charter on Human and Peoples' Rights into its domestic law, with the result that all the rights contained therein can be invoked in Nigerian courts in what is, in essence, an action for breach of statutory duty.

As has been mentioned, the 1999 Nigerian Constitution outlines the Fundamental Objectives and Directive Principles of State Policy<sup>234</sup> like in the Constitutions of other African countries,<sup>235</sup> except, originally,<sup>236</sup> South Africa, which entrenched

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challenge to allow the enforcement of health care rights, there are other barriers to such litigation. For example, dilatory judicial procedures, the restrictive rules on standing to sue (*locus standi*), the stultification of adjudication on substantive rights by unnecessary and prolonged interlocutory appeals, and the material poverty of potential health litigants all negatively affect the prospect of health rights litigation. As this is a book about health care rights, which addresses right-to-health litigation, it may seem at first blush that Nigeria has little to contribute. Indeed, legal analysts of despair at the dearth of health-related litigation in Nigeria. For example, toward the end of his analysis on the judicial enforcement of socio-economic rights in Nigeria, Chidi Odinkalu lamented that there 'is inadequate material for any serious quantitative analysis and the jurisprudence ... hardly profits rigorous analysis'. Nevertheless, there are a few cases in Nigeria that involve health concerns, such as those in which an accused person used their ill health to sustain an argument for bail in criminal proceedings, as well as custodial cases in which prisoners alleged that their ill-health rendered their continued incarceration without treatment unjustifiable. Given that these cases were primarily concerned with the enforcement of the claimant's civil and political rights, they are only tangential to the enforcement of a constitutional right to health. In essence, there is not a single reported Nigerian judicial decision that squarely raises the constitutional issue of the right to health."

<sup>232</sup> In *Soombramoney v Minister of Health (Kwazulu-Natal)* [1997] ZACC 17, at para 11, Chaskalson P stated: "[T]he obligations imposed on the state by sections 26 and 27 [1996 Constitution of South Africa] in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and that the corresponding rights themselves are limited by reason of the lack of resources and the significant demands on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled."

<sup>233</sup> The State shall direct its policy towards ensuring that – (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; (d) there are adequate medical and health facilities for all persons.

<sup>234</sup> Chapter II.

<sup>235</sup> Shedrack C Agbakwa, *Reclaiming Humanity: Economic, Social, and Cultural Rights as the Cornerstone of African Human Rights* (2002) 5 Yale Human Rts & Development L J 177, at 186-187 states: "The point is often made that development of Africa, and indeed of all Third World states, is a necessary precondition for the enforcement and enjoyment of ESCR. It has been contended that African states cannot reasonably be expected to fulfill their ESCR obligations under the African Charter given their socio-economic problems, which arise from under-development and 'existing patterns of international trade'. Scholars have also asserted that the poverty of African states justifies treating ESCR as principles of state policy (as they are in the constitutions of Nigeria, Cameroon, Lesotho, Malawi, Namibia, Sierra Leone, and Tanzania). African states are, no doubt, among the most impoverished states of the world. This fact makes the argument that they are too poor to realize ESCR very compelling."

<sup>236</sup> More recently, new constitutions in Kenya and Zimbabwe have followed South Africa's example and moves are afoot in Malawi and Tanzania to follow the same path.

socio-economic rights as constitutional rights<sup>237</sup>, subject to the proviso of their progressive achievement.<sup>238</sup> However, these Objectives and Principles do not confer any legal right on its citizens to require the courts to enforce the constitutional provisions under Chapter II in the event of non-compliance by the Government by virtue of s. 6(6)(c) of the Constitution.<sup>239</sup>

The above constitutional provision fell for interpretation in *Okogie & Ors v Attorney General of Lagos State*.<sup>240</sup> The plaintiffs challenged the constitutionality of the defendants' policy decision to abolish private schools within the State, arguing that it was in violation of the right to education guaranteed under s. 16(1)(c) (Chapter II) of the former 1979 Constitution which is the equivalent of s. 18 (Chapter II) of the 1999 Constitution. The High Court held that by s. 6(6)(c) of

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<sup>237</sup> 1996 Constitution, sections 26-29.

<sup>238</sup> In *Government of the Republic of South Africa & Ors v Grootboom & Ors* [2000] ZACC 19, at para 38, the Constitutional Court held: "[Section 26.1] generally imposes obligation upon the state the right of everyone to have access to adequate housing. However, section 26(2) makes it clear that the obligation imposed upon the state is not an absolute or unqualified one. The extent of the state's obligation is defined by three key elements that are considered separately: (a) the obligation to 'take reasonable legislative and other measures'; (b) 'to achieve the progressive realisation' of the right; and (c) 'within available resources.'" The Constitutional Court affirmed *Grootboom* decision in *Khosa & Ors v Minister of Social Development* [2004] ZACC 11, at paras 109-110, Ngcobo J stated: "Section 27(1) and (2) must be read together to give content to the right of access to social security. Section 27(1) delineates the scope of the right by vesting the right in everyone. ... Section 27(2) imposes a positive obligation upon the state 'to devise a comprehensive and workable plan to meet its obligations in terms of the subsection. However, this is a qualified obligation to '(a) take reasonable legislative and other measures; (b) to achieve the progressive realisation of the right; and (c) within available resources'."

<sup>239</sup> Amy Sinden, *An Emerging Human Right to Security from Climate Change: The Case Against Gas Flaring in Nigeria* (2008) 77 Legal Studies Research Paper Series 1, at 9-11. The author identified the obligations and justifiability of specific rights under three different human rights instruments, states: "Human rights have evolved roughly in three waves. Civil and political human rights ... Economic and social rights, and a 'third generation' of human rights – attach to groups rather than individuals and are aimed at the preservation of cultural identity and self-determination. Second and third generation rights may seem at first blush more amenable to the accommodation of a climate change right. Economic and social rights typically include a right to health and sometimes even an explicit right to a healthy environment, and third generation rights often include a right to the free use of natural resources. But second and third generation rights are generally less enforceable than civil and political rights. First, they are typically expressed in less binding terms. For, example, the ICESR only calls on States to 'take steps' to achieve the enumerated rights 'up to the maximum of available resources'. The International Covenant on Civil and Political Rights, by contrast, directs each State to 'undertake to respect and to ensure [the enumerated rights] to every individual within its territory. Moreover, second and third generation rights are often framed in explicitly non-justiciable terms. Many Constitutions, for example include them in a separate section designated for non-justiciable rights. ... In sum, civil and political rights, with their centuries-old pedigree, enjoy far more acceptance and are far more likely to be viewed as enforceable by the courts than second and third generation rights. Accordingly, a climate change right is likely to be far more effective both rhetorically and legally if it is grounded in traditional civil and political rights."

<sup>240</sup> (1981) INCLR 218.

the 1979 Constitution (which is same with s. 6(6)(c) of the 1999 Constitution), the provisions of Chapter II of the Constitution were not enforceable and that no court had jurisdiction in the matter<sup>241</sup>. However, the Supreme Court in the case of *Attorney-General of Ondo State v Attorney-General of the Federation & Ors*,<sup>242</sup> expressed willingness to enforce Directive Principles as justiciable rights, holding that it can be made justiciable by legislation<sup>243</sup>.

Emeka Polycarp Amechi has remarked that the Nigerian judicial attitude to the Directive Principles is influenced by the initial position of the Indian Supreme Court with regard to the justiciability of Article 48A of the 1949 Indian Constitution, which is similar to section 20 of the Nigerian Constitution.<sup>244</sup>

In recent times, Nigerian courts have taken a wider view of their role in interpreting the Constitution by making reference to the regional and international instruments for the enforcement of the right to health<sup>245</sup> by inference or derivation from the right to life<sup>246</sup>. Although Chapter IV (Fundamental Rights) of the 1999 Constitution

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<sup>241</sup> *Ibid.*, Agoro J stated (at 231):

“[T]he Directive Principles of State Policy in Chapter XI of the Constitution have to conform to run as subsidiary to the Fundamental Rights under Chapter IV of the Constitution. If there is no infringement of any Fundamental Right: there can be no objection to the State acting in accordance with the Directive Principles set out in Chapter XI, subject of course to the legislative and executive powers conferred on the State.”

<sup>242</sup> (2002) 9 NWLR (Pt. 772) 222.

<sup>243</sup> *Ibid.*, Uwaifo JSC stated:

“As to the non-justiciability of the Fundamental Objectives and Directive Principles of State Policy in Chapter II of our Constitution, section 6(6)(c) says so. While they remain mere declaration, they cannot be enforced by legal process but [it] would be seen as a failure of duty and responsibility of State organs if they acted in clear disregard of them. ... But the Directive Principles (or some of them) can be made justiciable by legislation.”

<sup>244</sup> Emeka Amechi, *Litigating Right to Healthy Environment in Nigeria: An Examination of the Impacts of the Fundamental Rights (Enforcement Procedure) Rules 2009, In Ensuring Access to Justice for Victims of Environmental Degradation* (2010) 6(3) Law, Environment and Development Journal 320, at 326.

<sup>245</sup> Remigius N. Nwabueze, “The Legal Protection and Enforcement of Health Rights in Nigeria”, Chapter 14 of C Flood & A Gross eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014) 371, at 382, remarks: “One of the possible strategies is to deploy the African Charter on Human and Peoples’ Rights as a basis for articulating health rights in Nigeria. Another strategy, which has found favor with Indian courts, is to embed the right to health within the right to life, which is enforceable under the Nigerian Constitution.”

<sup>246</sup> 1999 Constitution, Chapter IV (Fundamental Rights): Right to life – S. 33(1) Every person has a right to life, and no one shall be deprive intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria. S. 34(1): Right to dignity of human person – Every individual

does not provide for a right to environment, it provides for substantive personal rights. In *Gbemre v Shell Petroleum Development Company Nigeria Ltd & Ors*,<sup>247</sup> the plaintiff claimed that the gas flaring activities in Iwherekan community in Delta State of Nigeria by the first and second respondents were a violation of their fundamental rights to life and dignity of the human person and to a healthy life in a healthy environment. The Federal High Court, Benin Judicial Division held that the actions of the first and second respondents in continuing to flare gas in the course of their oil exploration and production activities in the applicants' community was a gross violation of their fundamental right to life (including healthy environment) and dignity of the human person as enshrined in the Constitution.

The Court took the view that the provisions of s. 3(2) of the Associated Gas Re-Injection Act, Cap A25, Vol. 1, Laws of the Federation of Nigeria, 2004 and s. 1 of the Associated Re-Injection (Continued Flaring of Gas) Regulations, 43 of 1984, under which gas flaring in Nigeria might be continued, were inconsistent with the provisions of sections 33(1) and 34(1) of the 1999 Constitution of the Federal Republic of Nigeria and Articles 4, 16 and 24 of African Charter on Human and Peoples' Rights.

It is evident in the reasoning of the court that it acknowledged that gas flaring is harmful to human life and the environment, which has significant adverse effects on human beings and on their means of livelihood.<sup>248</sup> Thus, the court expanded the interpretation of the right to life so as to encompass the right to healthcare or protection of health, which includes a healthy environment, by interpreting the

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is entitled to respect for the dignity of his person, and accordingly – (a) no person shall be subjected to torture or to inhuman or degrading treatment; ...

<sup>247</sup> (2005) AHRLR 151. For analysis of the decision, see Olufemi Amao, *Corporate Social Responsibility, Multinational Corporations and the Law in Nigeria: Controlling Multinational in Host States* (2008) 52 J of African L 89, at 107-110; Hakeem Yusuf, *Oil on Troubled Waters: Multi-national Corporations and Realising Human Rights in the Developing World, with Specific Reference to Nigeria* (2008) 8 African Human Rts L J 79, at 93-94.

<sup>248</sup> Cf Damiloa Olawuyi, *Legal and Sustainable Development Impacts of Major Oil Spills* (2012) 9(1) Consilience: The Journal of Sustainable Development 1, at 9.

fundamental rights to conform with the Fundamental Objective and Directive Principles of State Policy in relation to s. 20<sup>249</sup> particularly, and for every citizen to enjoy their constitutional rights to live in a healthy environment. Thus, the Fundamental Objectives and Directive Principles of State Policy cannot be separated from Fundamental Rights.<sup>250</sup>

The Lagos State High Court delivered a landmark judgment in *Georgina Ahamefule v Imperial Medical Centre & Anor.*<sup>251</sup> The Social and Economic Rights Action Centre (SERAC) represented the plaintiff, who had been denied medical care and had her appointment terminated by the defendant on the basis of her HIV status. Such treatment, the plaintiff argued, was violation of her right to health and a breach of the requirement for informed consent, as well as constituting discrimination and the tort of negligence.

The case was initiated in 2001. Upon an application for accelerated hearing brought by the plaintiff, the presiding judge dismissed the case and barred the plaintiff from entering the court room as a result of her HIV positive status, fearing that her presence in the court room would expose the court to a risk of infection. SERAC appealed the decision and the Court of Appeal remitted the case back to the High Court for retrial, where the plaintiff testified without any restriction or impediment.

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<sup>249</sup> 1999 Constitution of Nigeria – Environmental Objectives: The State shall protect and improve the environment and safeguard the water, air and land, forest and wild life of Nigeria.

<sup>250</sup> Cf Abdulkadir Bolaji Abdulkadir, *Gas Flaring In The Niger Delta of Nigeria: A Violation of The Right To Life And Comment On The Case of Gbemre v Shell Petroleum Development Company of Nigeria Ltd* (2014) 22(1) *Illum Law Journal* 75, at 90: “The case of *Gbemre v Shell* (2005) AHRLR 151, is a celebrated case in Nigeria because it is the first judicial authority to declare that gas flaring is illegal, unconstitutional, and a breach of the fundamental human right to life. This case is a clear indication that a healthy environment is fundamental to the realisation of basic human rights and is significant to Nigerian because of two reasons. First, it pictures how gas flaring constitutes a threat to the enjoyment of the right to life ... This shows that matters concerning the protection of the environment can be brought under the purview of human rights. Secondly, the case also mirrored how the right to life has been expanded or interpreted in a wider perspective to include the protection of the environment and the enjoyment of a healthy environment. This is an indication that the existing human rights provisions in the Nigerian Constitution can go a long way to foster the right to a healthy environment. Thus, since environmental problems can affect the enjoyment of basic human rights, there is therefore nothing inconsistent in bringing environmental matters under the umbrella of human rights.”

<sup>251</sup> 27 September 2012 (Lagos State HC, Nigeria). See Obiajulu Nnamuchi, *Millennium Development Goal 6 and the Trifecta of HIV/AIDS, Malaria and Tuberculosis in Africa: A Human Rights Analysis* (2014) 42 *Denver J of Int'l L & Policy* 247, at 262-263.



The court in its findings (without detailed examination of more fundamental questions<sup>252</sup>) took the view that HIV testing without informed consent constitutes a claim in battery and held that the defendants' action in denying the plaintiff medical care on grounds of her HIV positive status constituted a flagrant violation of the right to health guaranteed under Article 16 of the African Charter and Article 12 of ICESCR.

The State had a responsibility to its people to seek to achieve the objective realization of the right to health without discrimination, which includes access to essential medicines.

In *Odafe & Ors v Attorney-General*,<sup>253</sup> the plaintiffs, prison inmates diagnosed as HIV/AIDS carriers who had been denied access to medical treatment, alleged that their denial of treatment arose on the basis of their HIV positive status was discriminatory in violating section 42 of the 1999 Constitution of Nigeria<sup>254</sup> and Article 2 of the African Charter. The court in consideration of the alleged discrimination was of the opinion that the provisions of the Constitution did not prohibit nor protect discrimination on account of health<sup>255</sup>. However, the court found liability against the defendants for violation of right to health as guaranteed under the African Charter on Human and Peoples' Rights. Nwodo J accepted that

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<sup>252</sup> Ebenezer Durojaye, *So sweet, so sour: A commentary on the Nigerian High Court's decision in Georgina Ahamefule v Imperial Hospital & Anor* (27 September 2012) relating to the rights of persons living with HIV (2013) 13 African Human Rts L J 464, at 478-479, in his analysis of the issues that were involved in the case, concluded: "[T]he decision of the Nigerian High Court in *Ahamefule* is a welcome development as it can potentially advance the rights of people living with HIV in Nigeria. However, the major gaps in this decision relate to the failure of the Court to clearly articulate the human rights of people living with HIV in line with international human rights principles and standards. For instance, while the Court found that conducting HIV testing without informed consent amounts to unlawful battery, it failed to examine the implication of this from a human rights perspective. More disappointingly, the Court ignored or failed to engage on whether the termination of the plaintiff's employment based on her HIV status constituted an act of discrimination contrary to the Nigerian Constitution and the African Charter. This was a missed opportunity for the Court to deal with a very pertinent issue that has continued to deter HIV positive persons from living a dignified and meaningful life. For many years, HIV related stigma and discrimination have continued to fuel human rights violations and to hinder efforts aimed at curbing the spread of the epidemic."

<sup>253</sup> (2004) AHRLR 205.

<sup>254</sup> S. 42(1) Right to freedom from discrimination: A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person ...

<sup>255</sup> *Odafe & Ors v A.G* (2004) AHRLR 205, at para 30, Nwodo J stated: "[T]he right to freedom from discrimination as enshrined in section 42(1) of the Constitution did not cover discrimination by reason of illness, virus or disease."

Article 16(2) of the Charter imposed a duty and obligations on the defendants to take necessary and other measures to realize the right to health of their people. The court held the view that socio-economic rights are widely recognized as justiciable claims in the courts when defining these rights in provisions of international or regional treaties that have been domesticated into national constitution. Nwodo J stated:

*“A dispute concerning socio-economic rights such as the right to medical attention requires the Court to evaluate state policy and give judgment consistent with the Constitution. I therefore appreciate the fact that the economic cost of embarking on medical provision is quite high. However, the statutes have to be complied with and the state has a responsibility to all the inmates in prison, regardless of the offence involved, ...”*<sup>256</sup>

### *Concluding Observations*

This broad overview of the international human rights instruments and constitutional provisions in several states has established that the right to health has a substantial reality rather than being a matter of mere sentimental rhetoric. It is capable of enforcement through the legal process, both international and national, and of yielding sanctions for its breach. Nevertheless, the limitations must also be frankly acknowledged. The sanctions of international law in this context are very weak. States that are in breach of their obligation to protect the right to health of

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<sup>256</sup> *Ibid.*, at para 38. WHO guidelines on HIV infection and AIDS in prison (1999), at para 1, states: “All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality.” UN General Assembly – Declaration of Commitment on HIV/AIDS (2001), at para 15, states: Recognizing that access to medication in the context of pandemics such as HIV/AIDS is one of the fundamental elements to achieve progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

their citizens will not be in the least concerned about these sanctions and will not change their healthcare policy from fear of them. In some modern democratic regimes in Africa, the embarrassment of being sanctioned by a monitoring Committee of an international human rights treaty may have some modest effect on public opinion and consequently on governmental policy. In Nigeria, however, this is not a matter of major concern to politicians. There is widespread lack of awareness in the general population of international human rights treaties.

More importantly, Nigeria has not ratified or signed the Optional Protocol for the International Covenant on Economic, Social and Cultural Rights. As regards this, Nigeria has, by legislation, incorporated the African Charter on Human and Peoples' Rights, which allows citizens to invoke the caselaw of the African Commission on the right to health, as well as any future relevant jurisprudence emerging from the African Court of Human and Peoples' Rights.

As regards the position under the Nigerian Constitution, it is true that the Constitution is drafted in a manner that does not encourage justiciability of the right to health. Nevertheless, we have seen that the Indian Supreme Court has been able to use the Directive Principles in a creative way to infuse its understanding of the right to life – a right that is clearly justiciable. Interpreting the right to life as embracing, in essence, the right to health, the Indian Supreme Court has managed to circumvent the restrictions on justiciability which Article 37 appeared to impose.

### *Implication for Medical Negligence Litigation*

The implications of this analysis of the right to health for patients who are victims of medical negligence must now be considered. As we shall see presently, medical negligence law recoils from addressing deficiencies at a macro level, treating these as falling outside the scope of the duty of care as they involve what are fundamentally political issues. Thus the victim of neglect at a macro level – as, for

example, where a hospital has no resources to buy an X-ray machine or, more mundanely, enough needles to do injections safely – will find his or her claim in tort dismissed as falling outside the scope of the duty of care. In theory, such a victim can initiate proceedings under the African Charter of Human and Peoples’ Rights, either under the domestic statutory law of Nigeria or if that failed) under the Charter itself before the African Commission or African Court of Human and Peoples’ Rights. The victim could – again in theory – make a complaint under the International Covenant on Civil and Political Rights, based perhaps on invidious discrimination. In reality, it is asking too much of victims to engage in this type of complex litigation. Moreover, the outcome, even if successful, may not involve any award of damages or an inadequate award and there is no guarantee that the Nigerian government would comply with its international law obligation to provide such remedy, if awarded.

It will be argued below that the best way forward is for the tort of negligence to be capable, albeit in a restrained way, of addressing gross deficiencies at a macro level. Just as courts internationally have demonstrated that they are capable of giving practical effect to the right to health in national constitutions without violating the principle of the separation of powers, so also in the context of the tort of negligence, macro decisions by governments, ministries or national or provincial departments of Health or other similar agencies should be capable of being subjected to scrutiny by courts to determine whether they involve a breach of the duty of the state to patients. Rather than being an absolutely “no go” area, such decision-making at a macro level should fall under the respectful consideration of the courts in tort litigation. In the draft Model Act, which I set out and describe in the concluding chapter of this thesis, I seek to provide for a novel way of dealing with this problem.

## **Chapter Four**

### **Background to Nigerian System of Tort Law**

#### *The Historical Background*

In this Chapter, the operation of the present system of professional negligence litigation in Nigeria is placed in its wider historical context.

The story is a somewhat complex one. The starting point is the reception of aspects of English law into Nigerian law. This occurred during the currency of the colonial rule. When Nigeria became independent on 1<sup>st</sup> October, 1960 the decision was made to maintain the former colonial strategy, not changing the date for

determining that reception. Section 45(1) of the Federal Interpretation Act<sup>257</sup> provides that:

*“... the common law of England and the doctrines of equity and the statutes of general application which were in force in England on 1<sup>st</sup> January, 1900 are applicable in Nigeria, only in so far as local jurisdiction and circumstances shall permit.”*

Similar provisions were included in the legislative codes of the three regions that constituted Nigeria and, later, the states that were created from these regions.<sup>258</sup>

*What are "Statutes of General Application"?*

The Nigerian courts have had to deal with several issues that this approach inevitably raises. The first involves the identification of “statutes of general application”. In the context of tort law, this is perhaps not a matter of the most profound importance as there had been very limited statutory intervention in England during the Nineteenth century into the corpus of tort law, which was overwhelmingly of judicial creation. To resolve this question, two questions must be answered:

“(i) By what courts [was] the statute applied in England?

(ii) To what classes of the community in England [did] the Act apply?”<sup>259</sup>

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<sup>257</sup> Cap. 89, Laws of Nigeria (1958).

<sup>258</sup> See Kodilinye & Aluko, *The Nigerian Law of Torts* (2<sup>nd</sup> ed, Spectrum Books Ltd, 1999) at 10-11.

<sup>259</sup> Antony N. Allott, *Essays in African Law* (Butterworth 1960), at 9, referring to the judgment of Osborne CJ in *Attorney-General v John Holt* (1910) 2 NLR 1, at 21.

On the basis of this test, the Fatal Accidents Act 1846, the Employers' Liability Act 1880 and the Slander of Women Act 1891 have been characterised as statutes of general application.

Of course, the legislation of Nigeria and its component states, over several decades, have had the option of introducing new legislation to repeal, amend or replace the pre-1900 English enactments. They have availed themselves of this opportunity in such areas as defamation<sup>260</sup>, fatal accidents<sup>261</sup>, contributory negligence<sup>262</sup>, the liability of joint tortfeasors<sup>263</sup>, occupiers' liability<sup>264</sup> and employers' liability<sup>265</sup>. In other areas, such as product liability<sup>266</sup>, employers' liability<sup>267</sup>, protection from harassment<sup>268</sup>, interference with goods<sup>269</sup>, liability for animals<sup>270</sup> and liability for defective premises<sup>271</sup>, Nigerian legislatures have not sought to incorporate or modify English statutory initiatives post-1900. As a broad observation, it may be said that the Nigerian legislatures have not been proactive in the area of tort law

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<sup>260</sup> See, *eg*, Defamation Law 1961 (Cap 34, Laws of Lagos State (1973)); Defamation Law 1959 (Cap 32, Laws of Western Nigeria 1959), Defamation Law 1962 (Laws of Eastern Nigeria 1963); all cited by Kodilinye & Aluko, *The Nigerian Law of Torts* (2<sup>nd</sup> ed, Spectrum Books Ltd, 1999), at 11. For critical analysis of contemporary Nigerian defamation law, see Imo Udofa, *Right to Freedom of Expression and the Law of Defamation in Nigeria* (2011) 2 Int'l J of Advanced Legal Studies & Governance 75; Tayo Oyetibo (SAN), *Navigating Defamation: How the Mass Media Can Avoid Pitfalls*, a paper presented at the GM Ibru & Co, Seminar on the Law of Defamation (13 November 2012). [www.tayooyetibolaw.com/admin/doc/135663277.doc](http://www.tayooyetibolaw.com/admin/doc/135663277.doc).

<sup>261</sup> Fatal Accidents Law 1961 (Cap 40) (Lagos State); Tort Law (Cap 1220) (Western States); Fatal Accidents Law (Cap 52); (Eastern States); Fatal Accident Law (Cap 43), (Northern States); Kodilinye & Aluko, *op. cit.* fn 257, *supra*, 267.

<sup>262</sup> See, *eg*, Law Reform (Torts) Act 1961, Cap 67; Law of Lagos State (1973), Part 5.

<sup>263</sup> *Ibid.*, Part 4.

<sup>264</sup> *Ibid.*, Part 3.

<sup>265</sup> *Ibid.*, section 3 (abolition of the defence of common employment).

<sup>266</sup> Consumer Protection Act 1987, Part 1.

<sup>267</sup> Employers' Liability (Defective Equipment) Act 1969.

<sup>268</sup> Protection from Harassment Act 1997.

<sup>269</sup> Torts (Interference with goods) Act 1977.

<sup>270</sup> Animals Act 1971.

<sup>271</sup> Defective Premises Act 1972.

and even their statutory initiatives, largely modelled on English legislation of half a century ago,<sup>272</sup> are in need of radical overhaul.

### *The Temporal Reference to "The Common Law of England"*

The second matter that requires a resolution in the light of the Interpretation Act relates to the temporal reference of “the common law of England”. The problem may be posed as follows. Are Nigerian courts to apply *the common law of England as it existed in 1900* or *the common law of England today*? Either solution seems mired in difficulty. If Nigerian courts are obliged to apply the common law of 1900, especially in the context of tort law, where there has been a vast transformation in the scope of the tort of negligence over the past century, they will be forced to stultify the development of their own law, freezing in place the long discredited principles of the law of a foreign country.<sup>273</sup> If, on the other hand, Nigerian courts are in 2016 required to apply the contemporary principles of English common law, the Nigerian courts will still be attached umbilically to a foreign law – the law of the former colonial power – which is a significant restriction on their own independent capacity and scarcely compatible with true national sovereignty.

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<sup>272</sup> Jill Cottrell, *The Tort of Negligence in Nigeria* (1973) 17 *Journal of African Law* 30, at 30, observed, “Academic disputation continues as to whether Nigerian courts are bound to apply English decisions subsequent to 1900. From a practical point of view, however, such decisions are treated as authorities which ought to be followed unless there is strong reason to the contrary. In the area of tort, only when the question of damages has arisen have judges in Nigeria shown conspicuous signs of independence – *Salihu v Tin Associated Minerals Ltd* [1958] NRNLR 99. For practical purposes, therefore, one may treat the Nigerian law of tort as being identical with that of England except where the latter has been modified by statute. The tort of negligence has, of course, been little affected by legislation in England.”

<sup>273</sup> Jill Cottrell, *The Functions of the Law of Torts in Africa* (1988) 31 *Journal of African Law* 161, at 163, stated, “It is interesting to note what the law is not doing. Especially striking is the dearth of ‘new’ torts ... Just as in a famous criminal case a Nigerian court refused to recognise a belief in witchcraft as giving rise to a defence to a murder (*R. Gadam* (1954) WACA 442), so the courts have refused to hold that it could be a tort to subject another to a fetish. Even within the scope of the existing torts have rarely pushed against the boundaries; the courts have been followers and the decisions they have followed have been those of English courts.”



There has been a lively debate<sup>274</sup> on the matter, extending over the past half century. It seems fair to say that this debate has been affected by the gradual erosion of the declaratory theory of the common law, which regards courts as merely enunciating rather than proactively developing the principles of the common law. Under such a theory, dates such as 1<sup>st</sup> January 1900 are of no great importance as the corpus of the common law is essentially unchanging and the function of the judge is to identify rather than change the relevant principles. The declaratory theory has almost no support today.<sup>275</sup> In relation to tort law, and the law of negligence in particular, the theory could have no credibility: it is simply impossible to harmonise with the revolutionary transformatory holdings in *Donoghue v Stevenson*<sup>276</sup> or *Hedley Byrne & Co v Heller & Partners*<sup>277</sup>, for example, or, conversely, with the great decisions of retrenchment in the scope of the duty of care, such as *Caparo Industries Plc v Dicman*<sup>278</sup>.

Not unrelated to the declaratory theory was a formalistic emphasis on the principle of *stare decisis* and, in the context of the colonial application of English law, an insistence that the ultimate source of judicial authority was located in London, expressly in terms of the role of the Judicial Committee of the Privy Council<sup>279</sup> and

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<sup>274</sup> See Antony N. Allott, *Essays in African Law* (Butterworth 1960), at 9; A. E. W. Park, *The Sources of Nigerian Law* (London: Sweet & Maxwell, Lagos: African University Press, 1963).

<sup>275</sup> Cf Lord Reid, *The Judge as Law Maker* (1972) 12 *Journal of the Society of Public Teachers of Law* 22, at 22: “There was a time when it was though almost indecent to suggest that judges make law – they only declare it. Those with a taste for fairy tales seem to have thought that in some Aladdin’s cave there is hidden the Common Law in all its splendour and that on a judge’s appointment there descends on him knowledge of the magic words *Open Sesame*. Bad decisions are given when the judge has muddled the pass word and the wrong door opens. But we do not believe in fairy tales any more”. For an attempt to rehabilitate the declaratory theory, on the basis that it was far more jurisprudentially sophisticated than represented by its critics, see Allan Beever, *The Declaratory Theory of Law* (2013) *Oxford Journal of Legal Studies* 421. See also Richard McManus, *Predicting the Past: The Declaratory Theory of the Common Law – From Fairytale to Nightmare* [2007] *Jud Rev* 228.

<sup>276</sup> [1932] AC 562.

<sup>277</sup> [1964] AC 465.

<sup>278</sup> [1990] 2 AC 605.

<sup>279</sup> Appeals from Nigeria to the Privy Council were abolished with the adoption of the Republican Constitution in October 1963, three years after Independence: see Bonny Ibwawoh, *Imperial Justice: Africans in Empire’s Court* (Oxford University Press 2013).

implicitly in terms of the pre-eminent status of the House of Lords. The *stare decisis* rule no longer holds absolute sway in Nigeria<sup>280</sup>.

### *Contemporary Approach of the Nigerian Courts*

In practice, as opposed to high theory, courts in Nigeria pay very considerable respect to decisions of the English courts<sup>281</sup> and there is no trace of any judicial attempt to freeze the common law by reference to 1<sup>st</sup> January 1900. Having said this, it should also be acknowledged that the references to English caselaw by the Nigerian courts, especially in the area of tort law, are often out of date, at times alarmingly so. Thus, for example, consideration of such a crucial aspect of tort law as the duty of care in negligence frequently involves the invocation by the Nigerian court of English decisions that have long since been modified or even abandoned in later English cases.

Why should this be so? Three reasons suggest themselves. First, there is only limited academic commentary on Nigerian tort law. Only one textbook<sup>282</sup>, by Gilbert Kodilinye and Oluwole Aluko, offers anything approaching a considered analysis of the subject and even it is limited in size (less than 300 pages of text) and in its treatment of the tort of negligence (the themes of duty and standard of care, product liability, professional negligence, employers' liability, traffic accidents, proof of negligence and defences all being covered in 54 pages).

The second reason, historically, was a lack of up-to-date comprehensive access to English caselaw and academic commentary. This problem has eased with the development of easy free electronic access to the judgments of the English courts

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<sup>280</sup> See *Odi v Osafire* [1985] 1 SC 37.

<sup>281</sup> See Cottrell, *The Tort of Negligence in Nigeria* (1973) 17 *Journal of African Law* 30, at 30.

<sup>282</sup> Kodilinye & Aluko, *The Nigerian Law of Torts* (2<sup>nd</sup> ed, Spectrum Books Ltd, 1999). The most recent edition of this work was published 16 years ago.

but there still is a difficulty with academic commentary, which generally is accessible only on sites requiring the substantial payment of fees.

The third reason for the continuing reliance on English decisions by the Nigerian courts is the endemic tendency of post-colonial states to cleave to the judicial rulings of the former imperial power. This was a feature of many Commonwealth countries, including Canada,<sup>283</sup> though it has eased in those other countries in recent decades.

The main features of contemporary Nigerian tort law would be entirely familiar to an Irish or British lawyer. The system is based on the traditional menu of torts, ranging from trespass, through negligence, to strict liability under the rule in *Rylands v Fletcher*<sup>284</sup>. Strict product liability is not part of the menu. In terms of litigation practice, there is a greater emphasis on torts where the defendant has intentionally harmed the plaintiff, such as battery, false imprisonment, malicious prosecution and defamation, than is the position in Irish and British courts.<sup>285</sup> This pattern is reflected in other African countries and is probably related to the cultural understanding of the function of tort law as being more concerned with the vindication of personal dignitary intending than with affording a mechanism of compensation for unintended injuries associated with urban and industrial life.

In the context of medical negligence litigation, the Nigerian courts have shown themselves to be conservative. Their citation of case law from Britain has been passive rather than involving any detailed critical analysis as to whether the British courts were correct or sensible in the conclusions reached in their judgments. There is little evidence that Nigerian judges have immersed themselves in the wider

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<sup>283</sup> See Bruce Feldthusen, *City of Kamloops v Nielson: A commentary on the Supreme Court's Modest Clarification of Colonial Tort Law*. (1985) 30 McGill LJ 539, at 556-558, deprecating the Supreme Court of Canada's continuing deference to British caselaw and academic commentary, to the neglect of Canadian judgments and scholarly analysis.

<sup>284</sup> [1868] LR 3 HL 300; [1866] LR 1 Ex. 265.

<sup>285</sup> See further Cottrell, *The Functions of the Law of Torts in Africa*. (1988) 31 Journal of African Law 161, at 162.

academic debate on medical negligence litigation. Instead, there is a willingness to discuss claims on grounds of evidential insufficiency without any serious consideration of the substantive issues of principle and policy.

## **Chapter Five**

### **The Duty of Care in Medical Negligence**

#### *Introduction*

In this chapter, the duty of care in negligence is analysed. This concept is of importance as it sets the outer parameters of liability for negligence claims, including claims for professional negligence against medical personnel, by prescribing the circumstances in which negligent conduct causing injury will be actionable.<sup>286</sup>

#### *Policy Considerations Underlying Abstract Conceptualisation*

At the threshold of this chapter, a two general points may be made. First, while the jurisprudence internationally on the duty of care is highly conceptual, with reference to such abstract notions as "proximity of relationship", "neighbourliness" and "justice", the question whether to impose (or, more particularly, *not* to impose) a duty of care is quintessentially one of *policy*. Policy is not an easy notion to pin down but it relates to the world of practicalities rather than principle: courts may decline to impose a duty of care in situations where they consider that, however meritorious the plaintiff's claim may be in principle, the imposition of a duty of care would simply be unworkable from a social, political or economic perspective.

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<sup>286</sup> Cf *Elpe Finance Ltd v Brymun Ltd & Anor* [2011] 2 Zambia L R 462, at 473 (*per* Mutuna J).

In that regard, the duty of care operates as a "control device"<sup>287</sup>, reining in the scope of potential liability to compensate all victims of careless conduct.

A second point to be noted is that the Nigerian courts (as well as the courts of other common law jurisdictions in Africa) appear not to have engaged seriously in the process of gradual expansion of the duty of care epitomised by such English cases as *Dorset Yacht*<sup>288</sup> and *Anns*<sup>289</sup>, followed by a radical constriction of that duty epitomised by *Caparo*<sup>290</sup>. It is true that *Anns* is still cited in Nigerian (and other African) judgments but there is no indication from the analysis contained in these judgments that any particular weight is being placed on the nuances in formula which carried so much hidden meaning in the history of the application of the duty of care in the common law jurisdictions of England, Scotland, Ireland, Canada and Australia.

#### *Failure of Nigerian Courts to Develop Nuanced Analysis*

The fact that the Nigerian jurisprudence on the duty of care lacks resonances of this nuanced jurisprudence makes it harder to assess the future development of negligence law in Nigeria. It is relatively straightforward in England, following *Caparo*, to understand that English courts today prefer incrementalism to broad statements of principle, are sceptical about permitting recovery for negligently caused pure economic loss and are equally reluctant to place burdens on public authorities in the discharge of their statutory functions.

The formula for the ingredients of the duty of care spelt out in *Caparo* was designed to overturn the perceived expansiveness of the formula adopted more than

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<sup>287</sup> John G Fleming, *The Law of Torts* (9<sup>th</sup> ed, LBC Information Services 1998), at p 150, remarks: "One or more control devices were required to prevent the incidence of liability from getting out of hand. Among these, 'duty of care' occupies today a paramount position."

<sup>288</sup> *Dorset Yacht Co Ltd v Home Office* [1970] AC 1004.

<sup>289</sup> *Anns v Merton London Borough Council* [1978] AC 728.

<sup>290</sup> *Caparo Industries v Dickman* [1990] 2 AC 605.

a decade previously in *Anns*. In Nigeria, since the courts have no similar intent when using, variously and with no apparent particular preference, the *Anns* formula for the duty of care, it is difficult to be confident as to how they intend the actual content of the duty of care should develop in the future. The Nigerian courts have never expressly rejected *Caparo* but the truth of the matter is that they have never yet referred to it. This can scarcely be explained by their not being aware of that decision, although one could not exclude that possibility: the leading textbook<sup>291</sup> refers only to *Anns* and not to *Caparo*.

Certainly it can be said with some assurance that Nigerian courts are conservative in their appreciation of the duty of care concept. There is no evidence of an expansive judicial understanding based on a broad notion of proximity of relationship. In that regard, whereas the *Anns* formula has found favour in some Nigerian decisions, the philosophy underlying *Anns* never really took hold fully in Nigeria<sup>292</sup>.

Most of the Nigerian decisions are confined to an articulation of the broad principle in *Donoghue's* case with limited reference to Lord Wilberforce's two-stage test in *Anns v London Borough of Merton*<sup>293</sup> and hardly any emphasis on the role of policy factors in their decisions.

*Abusomwan v Mercantile Bank of Nigeria Ltd (No. 2)*,<sup>294</sup> is an example of the relative simplicity of approach to the duty of care question. The plaintiff, a businessman dealing with the importation of cement, entered into an arrangement to import cement from a New York company. The defendant bank opened a letter of credit in plaintiff's favour. However, it endorsed the documentation in favour of

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<sup>291</sup> Kodilinye & Aluko, *The Nigerian Law of Torts* (2<sup>nd</sup> ed, Spectrum Books Limited 1999).

<sup>292</sup> *Cf Anyah v Imo Concorde Hotels Ltd & Ors* (2002) 12 SC (Pt II) 77.

<sup>293</sup> [1978] AC 728.

<sup>294</sup> (1987) 3 NWLR (Pt 60) 196.

another business. The defendant's disregard of the instructions in the bankers' guarantee resulted in the defendant's notifying the arrival of the consignment to the other business. In consequence, neither the plaintiff nor his bank, which had issued a letter of credit, was informed of the arrival of the consignment. The Court below held the view that a third party to a contract cannot maintain an action in negligence for breach of contract. The Supreme Court rejected this approach and examined whether there was proximity of relationship between the parties, holding that the defendant had breached a duty of care by having disregarded the plaintiff's banker's guarantee. Karibi-White JSC stated:

*“The duty imposed here is not because there was a contract but because the defendant had impliedly undertaken not to injure the plaintiff ... the obligations towards the contracting party extended to all such persons who were likely to be injured by the acts or omissions of the defendant. They are the neighbours in contemplation or ought to be in contemplation of the defendant.”*

Karibi-White JSC concluded:

*“Surely, duty arising from proximity in law or fact, and not contract is a condition precedent for liability in negligence. ... I think the doctrine of proximity as the foundation of duty of care in tort, is now firmly established. It has replaced the erstwhile 'privity of contract' fallacy.”<sup>295</sup>*

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<sup>295</sup> *Abusomwan v Mercantile Bank Ltd (No. 2)* (1987) 3 NWLR (Pt 60) 196.

A similarly straightforward approach is evident in *Anyah v Imo Concorde Hotels Ltd.*<sup>296</sup> The plaintiff took up a room at the defendant's hotel for the night. He was given a plastic disc at the entrance by the security men on duty to park his car in a parking space therein. He locked the car and kept the car key to himself. The following morning, the plaintiff checked out of the hotel, went to pick his car where he kept it but the car was nowhere to be seen. As a result, he brought a claim in negligence against the defendants. The Supreme Court held that the fact that the plaintiff had been given the hotel disc to enter and park in the hotel premises, and the hotel posted its security men and policemen in and around the hotel, had merely happened to give the impression that the plaintiff's car would be protected from theft or damage but had not bound the defendants to provide such protection. No sufficient relationship of proximity existed between the parties. Kalgo JSC stated:

*“[T]he plaintiff is not such a neighbour that the defendants must or ought reasonably to have him in contemplation when directing their minds to their acts or omissions.”*

Kalgo JSC concluded:

*[T]here is no doubt that the loss of the plaintiff's car cannot be attributed to any act of negligence on the defendants having regard to the way they performed their duties on the fateful day and the relationship of the parties as narrated earlier in this judgment, no duty of care can be ascribed to them. If to say the defendants left the gates unattended, and the car was driven out through the gate, there may prima facie be a duty of care to the plaintiff. This was not the case*

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<sup>296</sup> (2002) 12 SC (Pt II) 77.



here.”<sup>297</sup>

This brief consideration of the case law on the duty of care in Nigeria demonstrates its rudimentary character, which makes it difficult to predict how Nigerian courts will determine key new issues regarding the duty of care in the context of medical treatment. All that can be said with confidence is that the Nigerian courts have displayed no radical tendencies: any argument for the imposition of the duty of care in a new context is likely to be closely scrutinised. This is especially so in respect of medical care, where the Nigerian courts have adopted a particularly conservative stance.

#### *The Duty of Care in the Context of Medical Treatment*

Generally, the issue of the duty of care in the context of medical treatment is not specifically addressed by courts, which concentrate on the separate question of the standard of care.<sup>298</sup> This is because there is, and can be, no debate that a doctor and other medical staff owe a duty of care to patients whom they are treating.

There are, however, some cases where the duty of care issue exceptionally can present itself as a discrete issue in the context of medical treatment. These include situations where no prior relationship exists between the ill person and the health professional. The traditional reluctance of courts to impose affirmative duties on

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<sup>297</sup> Cf *Universal Trust Bank of Nigeria v Fidelia Ozoemena* [2007] 3 NWLR 448, the plaintiff owned a 5-bedroom house while the defendant was her neighbour who owned a vacant land behind its office. The defendant’s vacant land was at all material times unoccupied but was fenced by a surrounding wall and secured by an iron gate. There was a fire outbreak which caught grasses and bushes on the vacant land and burnt the plaintiff’s adjoining house. The Supreme Court examined whether the damage which the plaintiff had suffered was a result of the negligent conduct of the defendant. The Court affirmed the *Donoghue* principle and held that the damage which the plaintiff suffered could not be within the reasonable contemplation of the defendant and it could not be found to have breached the duty of care owed to the plaintiff.

<sup>298</sup> In the odd case, courts in medical negligence litigation have adopted a duty of care analysis rather than that of the standard of care. See, eg, *Leah Wambui Githuthu v Attorney-General & Anor* [2005] eKLR. In the recent Nigerian decision of the Court of Appeal (Ilorin Division) in *Unilorin Teaching Hospital v Abegunde* [2015] 3 NWLR 421, at 450, Ogbuinya JCA in his judgment first addressed the duty of care, holding that the deceased patient “amply f[e]ll within the domain/ambit of neighbour”.

people – even professionals – to assist others can present difficulties in this context, as doctors, and health services generally, clearly have some obligation to provide emergency services.<sup>299</sup>

In Canada, the Supreme Court of British Columbia held that a doctor on duty had an obligation to examine and treat a patient in the casualty unit in *Egedebo v Windermere District Hospital Association*.<sup>300</sup>

The New South Wales Court of Appeal decision in *Woods v Lowms*<sup>301</sup> went so far as to impose a duty on a doctor to attend a patient in the patient's home.

In *Kent v Griffiths*,<sup>302</sup> the English Court of Appeal extended a duty of care to paramedics, as well as accident & emergency staff.

Let us now consider the possible impact of decisions such as *Woods v Lowms*<sup>303</sup> and *Kent v Griffiths*<sup>304</sup> on the law in Nigeria. Would it be practicable for courts to adopt such a broad interpretation of the duty of care? From one perspective, it might be argued that adopting this approach would be beneficial for Nigerian patients. It would extend the ambit of duty of medical personnel, would encourage a culture of proactive assistance and ensure compensation in cases of failure to provide it. From another perspective, which this thesis supports, such theoretical benefits would not be likely to occur in practice and would, in any event, involve an undue burden on a health care system that is already straining at the seams. Hospitals cannot cope

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<sup>299</sup> Anne F. Walker, *The legal duty of physicians and hospitals to provide emergency care* (2002) 166(4) Canadian Med Assoc J 465; Gray R. J, *Doctors, Samaritans and the Accident Victim* (1973) 11 Osgoode Hall L J 1; Williams Kevin, *Medical Samaritans: Is There A Duty To Treat?* (2001) 21 Oxford J of Legal Studies 393.

<sup>300</sup> (1993) 78 BCLR (2d) 63.

<sup>301</sup> (1996) Aust Torts Rep 81-376, 63, 151, analysed by Crowley-Smith Lynda, *Case Note* (1996) 3 James Cook U L Rev 137; Day Kylie, *Medical Negligence – the Duty to Attend Emergencies and the Standard of Care: Lowms & Anor v Woods & Ors* (1996) 18 Sydney L Rev 386; Stuart Malcolm, *Duty of Care – Clinical Applications* (2003) 22 Med & L 517, at 529-531; Mendelson Danuta, *Dr Lowms and the Obligation to Treat: Creative Lawmaking in the New South Wales Court of Appeal* (1996) 3 Tort L Rev 242.

<sup>302</sup> [2000] 2 WLR 1158. See William Kevin, *Litigation Against English NHS Ambulance Services and the Rule in Kent v Griffiths* (2007) 15 Med L Rev 153.

<sup>303</sup> (1995) 36 NSWLR 344 (SC).

<sup>304</sup> [2000] 2 WLR 1158.

with their present obligations; to extend further the scope of their duty would seem oppressive and unworkable. Negligence law should retain some close connection with the particular society to which it applies. Nigeria has a very undeveloped system of emergency response. It has been pointed out that:

*“Like so many African countries, Nigeria has no systemic pre-hospital emergency care, as such; patients with injuries are brought to the hospitals by bystanders, fellow passengers or law-enforcement agents using any form of transportation at hand.”*<sup>305</sup>

In these circumstances, where there is such a thin provision of emergency care, it may be argued that courts in Nigeria would actually risk frustrating the efficacy of such limited provision of emergency medical services by imposing a duty of care on those who provide them to follow up effectively on assurances made to those in need of their services. Accordingly, the Model Act on Medical Negligence Litigation, which I propose in the concluding chapter of this thesis, does not extend the duty of care to those who have not yet acquired the status of patient relative to the healthcare professional concerned.

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<sup>305</sup> By Oluwadiya, Olakulehin, Olatoke, Kolawole, Solagberu, Olasinde & Komolafe, *Pre-Hospital Care of the Injured in South Western Nigeria: A Hospital Based Study of Four Tertiary Hospitals in Three States* (2005) 49 *Annu Proc Assoc Adv Automot Med* 91, at 94. See further: Oludara, Idowu, Ibrahim, Mustafa, Ajani, Balogun & Solagberu, *Emergency Medical Services Outcome Assessment in Lagos, Nigeria: Review of Cases of "Brought in Dead" Patients* (2014) 7(2) *Macedonian Journal of Medical Science* 253; Solagberu, Ofoegbu, Abdur-Rahman, Adekanye, Udoffa & Taiwo, *Pre-Hospital Care in Nigeria: A Country Without Emergency Medical Services* (2009) 12(1) *Nigerian Journal of Clinical Practice* 29.

## **Chapter Six**

### **Professional Medical Negligence: General Principles**

#### *Introduction*

In this Chapter, I present an overview of how courts approach professional negligence in the context of healthcare. What unfolds is an account of strong judicial deference to the customary practices of medical and other professionals,

which, until quite recently – and still perhaps in Nigeria – amounted to close to complete surrender to the medical profession to determine the standard by which it was to be judged.

There are some good reasons for such deference: most professionals, after all, are highly intelligent people, engaged in a vocation with traditionally strong ethical standards, policed by a system of professional monitoring and sanctions. Nevertheless, while some deference was appropriate, a virtually complete surrender to customary professional practices clearly went too far. The old perception of medicine as an art rather than a science resulted in undue prestige attaching to those who practised this art. With the development of an evidence-based approach to medicine over recent decades, doctors are less easily regarded as infallible and there is an increasing tendency – eventually affecting the courts – to subject their practices to close critical scrutiny.

In Britain, traditional deference to the medical profession continued longer than in Canada, Australia, the United States of America or Ireland. What became known as the "*Bolam* test"<sup>306</sup> was understood to afford a defence to a doctor who adhered to a customary practice that found some support.

The House of Lords in *Bolitho v City and Hackney Health Authority*,<sup>307</sup> four decades after *Bolam*, departed from the conventional understanding of the *Bolam* test. Their Lordships emphasised that the words "responsible" body of medical men connoted a practice which withstands the scrutiny of "logical analysis" from a judicial point of view. Thus, a customary practice, even if favoured by a substantial

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<sup>306</sup> The name derived from the direction that McNair J gave the jury in the decision of *Bolam v Friern Hospital Committee* [1957] 1 WLR 582, where he said that the doctor would have a defence "if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art."

<sup>307</sup> [1998] 1 AC 232.

body of opinion, can still be negligent if such opinion fails to withstand logical analysis in matters of medical judgment, involving diagnosis and treatment<sup>308</sup>.

The judgment in *Bolitho* did not profess to be revolutionary. Lord Browne-Wilkinson emphasised that it would seldom be right for a judge to conclude that views genuinely held by a competent medical expert were unreasonable.

### *Nigeria<sup>309</sup> and Other African States*

In Nigeria, and African countries in general, the courts have tended to apply *Bolam* conservatively. In the present section, I shall examine these cases, which fall into three main categories:

- (i) cases where the plaintiff's claim is rejected for lack of expert evidence.
- (ii) cases involving the application of the *Bolam* test.
- (iii) cases involving application of the *Bolitho* test.

#### (i) *Cases Where the Plaintiff's Claim is Rejected for Lack of Expert Evidence*

It is a sad commentary on the lack of sophistication of the Plaintiffs' Bar in Nigeria and other common law jurisdictions that medical negligence claims are frequently launched and advanced at trial without expert medical evidence. The plaintiff comes to court and gives his or her account of what occurred but fails to back up allegations of negligence with coherent evidence from a medical expert. In such

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<sup>308</sup> *Bolitho v City and Hackney Health Authority* [1998] 1 AC 232, at 243.

<sup>309</sup> See Donald Dennis, *The curious case of medical negligence in Nigeria* (2014) 2 Int'l J of India Psychology 138; Okojie Eric, *Professional Medical Negligence in Nigeria*, <https://www.nigerianlawguru.com/articles/torts/PROFESSIONAL%20MEDICAL%20NEG>; Iyioha Irehobhude, "Medical Negligence", Chapter 4 of Iyioha & Nwabueze eds, *Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law* (Ashgate Publishing Ltd 2015) 65; Felix Chukwuneke, *Medical incidents in developing countries: A few case studies from Nigeria* (2015) 18 Nigerian J of Clinical Practice 20; Odikpo & Durojaye, "Litigating Health Right Issues: The Nigerian Experience", Chapter 6 of Durojaye ed, *Litigating the Right to Health in Africa: Challenges and Prospect* (Ashgate Publishing Ltd 2016) 141.

circumstances, it is no surprise that courts will heed the exculpatory evidence inevitably provided by experts on behalf of the defendant and dismiss the claim.<sup>310</sup>

Why should it be that claims are advanced without medical expert witnesses? Incompetence on the part of the plaintiff's counsel cannot be ruled out. One should not discount resource challenges, however: medical experts can be very expensive and beyond the means of impoverished plaintiffs. Moreover, it may be hard to find a doctor willing to give evidence criticising the conduct of another doctor.

Even in cases where the plaintiff is able to find some medical witness to give expert evidence, there is a real prospect that the defendant will be in a position to produce a more impressive expert. Thus, in the recent Nigerian case of *Unilorin Teaching Hospital v Abegunde*,<sup>311</sup> the Court of Appeal (Ilorin Division) was far more impressed by the expert evidence tendered by the defendant's witness "wear[ing] the rare, coveted and prestigious title of a consultant surgeon"<sup>312</sup> than by that tendered by the plaintiff's witness, a resident doctor. Ogbuinya JCA observed:

*"Being an expert witness, the law gives me the licence to crown his evidence with the toga of high probative value. On this score, the evidence of [defendant's witness] make mincemeat of those of [plaintiff's witness] in all aspects they were on collision course."*<sup>313</sup>

## (ii) Cases Involving the Application of the Bolam Test

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<sup>310</sup> See generally, *Abi v Central Bank of Nigeria* [2012] 3 NWLR 1; *Kopa v University Teaching Hospital Board of Management* [2007] ZMSC 8; *Edna Nyasalu v Attorney-General* [1983] ZR 105.

<sup>311</sup> [2015] 3 NWLR 421.

<sup>312</sup> *Unilorin Teaching Hospital v Abegunde* [2015] 3 NWLR 421, at 452.

<sup>313</sup> *Ibid.*, at 452-453.

In a number of Nigerian cases, the courts have applied a somewhat conservative model of the *Bolam* test, with a high degree of deference to customary practices. It is interesting to note, however, that *Bolam* can be invoked formally in circumstances where a more demanding test is substantively applied.

In *Abi v Central Bank of Nigeria*,<sup>314</sup> the plaintiff, an employee of the first defendant, took ill and was admitted in the second defendant's clinic where he was examined by the third defendant. The plaintiff claimed that the third defendant had negligently diagnosed, prescribed and administered on him drugs, including gentamycin, that made him permanently deaf. The Court of Appeal, Abuja Judicial Division found that the third defendant had conformed with an acceptable standard practice. Nwodo JCA said:

*“The courts have long recognized that there is no negligence if a doctor exercises the ordinary skill of an ordinary competent man professing to have that special skill. The locus classicus of the test for the standard of care required of a doctor or any other person professing some skill is the direction to the jury given by McNair J in Bolam v Friern Hospital Management Committee<sup>315</sup>.”<sup>316</sup>*

Nwodo JCA went on, however, to state:

*“Where the questio[n] of assessment of relative risks and benefit of adopting a particular medical practice is in issue [,t]he standard of reasonable care will presuppose that the relative risks and benefit have been weighed by the experts in forming their opinion. ... The judge is entitled to find the professional opinion reasonable or*

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<sup>314</sup> [2012] 3 NWLR 1.

<sup>315</sup> [1957] 2 All ER 118, at 122.

<sup>316</sup> *Abi v Central Bank of Nigeria* [2012] 3 NWLR 1, at 35-36.



*responsible [;] it is only when the trial judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the benchmark for reference ...*<sup>317</sup>

Thus, while professedly applying the *Bolam* test, Nwodo JCA effectively endorsed a test almost identical to that laid down by House of Lords in *Bolitho*, with its focus on the question whether a particular professional opinion can be logically supported. In *Abi*, the plaintiff's difficulty was not that the Court was excusing a particular practice which his expert witness had challenged but rather that he had produced *no* expert witness to show that the doctor had been negligent. In those circumstances, where expert evidence had been adduced by the defendants, it was inevitable that the plaintiff's claim would founder, without requiring the court to examine the differences between the *Bolam* and *Bolitho* tests.

A more conservative process of reasoning was adopted by the Supreme Court of Zambia in *Bwalya v Zambia Consolidated Copper Mines Ltd & Ors.*<sup>318</sup> The plaintiff, a married woman, underwent a bilateral tubal ligation (BTL) in 1997 at the second defendant's hospital. In August 1999, she had a miscarriage. Further, in October/November 1999, after a thorough medical examination was found to be about five weeks pregnant. In June 2000, she gave birth to a child through a caesarean operation. She brought a claim in negligence against the defendants. As in the case of *Abi v Central Bank of Nigeria*,<sup>319</sup> the plaintiff did not produce any expert medical witness in support of her claim. The Zambia Supreme Court based its conclusions, not surprisingly, on the evidence of the defendants' expert witness. Sakala CJ, delivering the judgment of the Court, noted that:

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<sup>317</sup> *Ibid.*, at 36.

<sup>318</sup> 20 April 2005 (Zambia SC).

<sup>319</sup> *Abi v Central Bank of Nigeria* [2012] 3 NWLR 1.

“... the test that has gained wide acceptance in medical cases as the proper approach in such cases was set out in the case of *Bolam v Friern Hospital Management Committee*<sup>320</sup>.”<sup>321</sup>

In the absence of any evidence contradicting that of the defendants’ expert witnesses, the plaintiff’s claim inevitably failed.

In *Kopa v University Teaching Hospital Board of Management*,<sup>322</sup> the plaintiff’s son, aged 8 years, swallowed a Coca-cola bottle cap on 25th December, 1998. The issue was whether the defendants were negligent in the oesphagoscopy procedure to remove the bottle cap. The Supreme Court of Zambia held that the defendants were not liable on the evidence of the plaintiff’s expert witness which corroborated the defendants’ evidence that they followed accepted and approved current practice<sup>323</sup>.

The Court here was clearly adopting the approach favoured by *Bolam*. Indeed, the Court itself acknowledged that earlier Zambian decisions had endorsed *Bolam* and it manifested unquestioning acceptance of that approach. The Court quoted with approval a passage from *Clerk & Lindsell on Torts*<sup>324</sup> stating the unqualified *Bolam* test. It is noteworthy that the edition of *Clerk & Lindsell* from which the Court was working was one stating the law three years before *Bolitho* was delivered.

### (iii) *Cases Involving the Application of the Bolitho Test*

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<sup>320</sup> [1957] 1 WLR 582.

<sup>321</sup> *Bwalya v Zambia Consolidated Copper Mines Ltd & Ors* (20 April 2005) Zambia SC, p 9.

<sup>322</sup> [2007] ZMSC 8.

<sup>323</sup> *Kopa University Teaching Hospital Management Board* [2007] ZMSC 8, Lewanika DCJ stated: “... the testimony of th[e] witness with regard to the propriety of the procedures adopted by the [defendant’s witnesses] in the management and treatment of the deceased child. His evidence was that the procedures were the normal accepted and approved current practice and there can therefore be no question of professional negligence.”

<sup>324</sup> (17<sup>th</sup> ed, Sweet & Maxwell, 1995) at para 11-12.

We have seen<sup>325</sup> how, in *Abi v Central Bank of Nigeria*,<sup>326</sup> Nwodo JCA, while formally applying the *Bolam* test, substantively applied the test adopted by the House of Lords in *Bolitho*<sup>327</sup>. There is also a fascinating dissenting judgment in a Ghanaian case decided seven years before *Bolitho* which anticipates prophetically the approach adopted by the House of Lords in *Bolitho*.

In *Gyan v Ashanti Goldfields Corporation*,<sup>328</sup> the plaintiff, a one-year old child, took ill, had a very high temperature and was taken to the defendant's hospital. The senior nurse who attended to the child at out-patient department mistakenly thought that he was suffering from malaria. The staff nurse administered a chloroquin injection on him without any prior test or reference to the doctor on duty. It turned out that the cause of the fever was not malaria but polio and that the administration of the chloroquin injection had resulted to the paralysis of the child's right leg.

The plaintiff alleged that the defendants had failed to follow prescribed regulations in treatment: if proper diagnosis had been made, it would have been discovered that the child had polio. In doing that, the administration of chloroquin injection would have been avoided and the child would have escaped paralysis. The defendants contended that the incidence of polio was far smaller than that of malaria, which had a very high mortality rate in children and that medical personnel would not have withheld injection for the treatment of malaria because of the small risk of paralysis from polio.

In determining whether the defendants were negligent in the treatment and whether the plaintiff's paralysis was a result of negligence, the majority of the Ghanaian Court of Appeal equated the status of nursing staff to that of a doctor. The defendants' witnesses had given evidence to the effect that they would have done

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<sup>325</sup> Supra, p 142-143, fn 419.

<sup>326</sup> [2012] 3 NWLR 1.

<sup>327</sup> *Bolitho v City and Hackney Health Authority* [1998] 1 AC 232.

<sup>328</sup> [1991] 1 GLR 466.

what the attending nurse had done and there was nothing unreasonable in the treatment he had prescribed. The Court applied the *Bolam* test, holding that the attending nurse should not be found liable<sup>329</sup>.

Ofori-Boateng JA, dissenting, dealt extensively on the evidence of the second and third defendants, who had claimed that they diagnosed malaria or polio without a test, based on their "clinical observation" of each patient. It was revealed that the nurse in question never carried out any test and had not the experience to distinguish polio from malaria. The dissenting judge further examined the evidence of the second and third defendants who claimed that, if they had detected malaria and had had to inject the plaintiff's child, they would have followed the procedure the nurse did, holding that this has not displaced negligence. Ofori-Boateng JA stated:

*"[T]he use of correct procedure for administering the wrong treatment contrary to all the precautions a cautious doctor would have taken, would under these circumstances still constitute gross negligence and not an exemption from it."*<sup>330</sup>

Ofori-Boateng JA, in support of this approach, referred to the *Bolam* test, laying emphasis, not on its apparent deference to customary practice, but rather on McNair J's insistence that the practice be one adopted by a "responsible body of medical men". Ofori-Boateng JA held that an accepted practice will not afford a defence if it is one fraught with negligence:

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<sup>329</sup> *Ibid.*, Essiem JA (at 474) stated: "I am of the opinion that on the evidence on record the senior nurse, the first defendants witness, who treated the infant plaintiff on his attendance at the hospital casualty ward did what most, if not all, medical men would have done in the circumstances."

<sup>330</sup> *Gyan v Ashanti Goldfields Corporation* [1991] 1 GLR 466, at 481.

*“But if the common practice is fraught with negligence, as I think the practice of the defendants’ hospital is, even if truly it is the practice of all the hospitals ... then the practice is not the one ‘which a responsible body of skilled medical men would accept as proper’.”*<sup>331</sup>

It is interesting to note how clearly Ofori-Boateng JA applied the test that the House of Lords subsequently adopted in *Bolitho*, which does not involve a complete judicial surrender to customary practice credibility of medical opinion.

### *Nigeria: The Best Way Forward*

At this point of our analysis, it may be advisable to consider how best Nigerian courts should develop the law in the future in regard to the professional negligence test. The most obvious solution would be to propose that they should endorse the *Bolitho* test, which contains some element of deference to customary practice while retaining the entitlement to hold negligent a particular practice that lacks a logical foundation. The *Bolam* test, as it had been applied for several decades, might be considered too deferential to customary practice, permitting illogical and unsafe practices to continue without sanction, to the detriment of injured plaintiffs certainly but also to the more general detriment of healthcare in Nigeria.<sup>332</sup>

Could it be argued that the present resource constraints on the delivery of healthcare in Nigeria make the imposition of the *Bolitho* test oppressive or unworkable? It is respectfully suggested that the answer is no. What the *Bolitho* test

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<sup>331</sup> *Gyan v Ashanti Goldfields Corporation* [1991] 1 GLR 466, at 482. The *Bolitho* approach has received the endorsement of the South African courts: *Michael & Anor v Linksfield Park Clinic (Pty) Ltd & Anor* [2001] ZASCA 12, approved by the Constitutional Court in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33.

<sup>332</sup> Irehobhude Iyioha, *Medical Negligence and the Nigerian National Health Insurance Scheme: Civil Liability, No-Fault, or a Hybrid Model?* (2010) 18(1) *African J of Int’l and Comparative Law* 46, the author (at 65) states: “As a persuasive precedent in Nigeria, the *Bolitho* decision can be influential in redirecting the current legal standard away from the professional standard towards a broader standard that incorporates both principles of patient autonomy and other forms of expert evidence that can ensure clinical accountability. An evolution in the applicable standards can have a positive effect on medical practice itself, thereby reducing adverse outcomes in medical treatment.”

does is require that medical practices not be illogical: it does not require that healthcare professionals work to a standard that cannot be reached on account of resource constraints. However limited a state's healthcare resources may be, it is not too much to ask of doctors that the healthcare that they *can* provide should not be vitiated by illogicality. The *Bolitho* test roots out egregious customary practices that should have no place in any healthcare system. In determining whether any particular practice has a logical foundation, courts in Nigeria would be entitled, and indeed required, to have regard to the economic and social restraints impacting on medical decision-making.

In the concluding chapter of this thesis, I propose Model Legislation incorporating the approach to professional negligence which I have just outlined as the most desirable one for Nigeria to follow.

## Chapter Seven

### Specific Aspects of Professional Medical Negligence

#### *Introduction*

In this Chapter, I examine specific aspects of professional medical negligence litigation in Nigeria. The areas I have chosen to focus upon raise important issues of policy on account of the significant weaknesses in the healthcare system of Nigeria. They are:

1. Obstetric and neonatal negligence
2. Wrongful birth and wrongful life
3. Psychiatric negligence
4. Nursing negligence.

#### 1. *Obstetric and Neonatal Negligence*<sup>333</sup>

In this section, I examine the law on obstetric negligence in Nigeria. The subject is a complex one as courts must seek to determine where blame should be ascribed against a background of a huge national problem of very high maternal mortality and morbidity during pregnancy and at childbirth.

Nigeria, with only 2.5% of the world's population, has 19% of the world's maternal deaths.<sup>334</sup> The contrast with the position in Ireland is stark. The maternal mortality

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<sup>333</sup> Adinma Joseph, *Litigations and the Obstetrician in Clinical Practice* (2016) 6 *Annals of Med & Health Sciences Research* 74; Philips, Ononokpono & Udofia, *Complicating causality : patient and professional perspectives on obstetric fistula in Nigeria* (2016) 18 *Culture, Health & Sexuality* 1. <https://dx.doi.org/10.1080/13691058.2016.1148198>.

<sup>334</sup> Ohaja & Murphy-Lawless, *Unilateral Collaboration: The Practices and Understandings of Traditional Birth Attendants in Southeastern Nigeria* (2017) 30 *Women and Birth* e 165, at e 166. See also Ezugwu, Onah, Ezugwu & Okafor, *Maternal Mortality in a Transitional Hospital in Enugu, South East Nigeria* (2009) 13 *African J of Reproductive Health* 67, at 68.

ratio in Ireland is 4/100,000 live births. In Nigeria in 2009 it was 800/100,000 live births.<sup>335</sup>

Millennium Development Goal No. 5 is to reduce maternal mortality by 75% between 1990 and 2015.<sup>336</sup> There has been a consistent reduction in maternal mortality in Nigeria over the past decade and a half.<sup>337</sup>

The percentage reduction in the maternal mortality rate between 1990 and 2010 was 41%.<sup>338</sup> The ratio of maternal deaths per 100,000 live births fell from 1200 in 1990 to 560 in 2013<sup>339</sup>.

### (i) *The Social and Cultural Contexts Impacting on Maternal Mortality*

It is impossible to understand the reasons for such high maternal mortality in Nigeria without regard to the wider social and cultural contexts.<sup>340</sup>

The lack of education<sup>341</sup> and the low status afforded women<sup>342</sup> have identified as crucial factors. A study of 21 health facilities in Nigeria reported in 2012 that:

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<sup>335</sup> Ohaja & Murphy-Lawless, *Unilateral Collaboration: The Practices and Understandings of Traditional Birth Attendants in Southeastern Nigeria* (2017) 30 *Women and Birth* e 165, at e 166. See also Ezugwu, Onah, Ezugwu & Okafor, *Maternal Mortality in a Transitional Hospital in Enugu, South East Nigeria* (2009) 13 *African J of Reproductive Health* 67, at 70.

<sup>336</sup> The Millennium Development Goals are derived from the United Nation Millennium Declaration of 2000, to which all 191 Members States committed themselves. See generally: Obiajulu Nnamuchi, *Millennium Development Goal 5, Human Rights, and Maternal Health in Africa: Possibilities, Constraints, and Future Prospects* (2014) 23 *Annals of Health Law* 92.

<sup>337</sup> See Kana, Doctor, Peteteiro, Lunet & Barros, *Maternal and Child Health Interventions in Nigeria: A Systematic Review of Published Studies From 1990 to 2014* (2015) 15 *BMC Public Health* 334; Antor Ndep, *Informed Community Participation Is Essential to Reducing Maternal Mortality in Nigeria* (2014) 2 *Int'l J of Health & Psychol Research* 26, at 26-27.

<sup>338</sup> World Health Organisation, Nigeria: Maternal and Perinatal Health Profile ([www.who.int/maternal-child-adolescent/epidemiology/profiles/maternal/nga.pdf](http://www.who.int/maternal-child-adolescent/epidemiology/profiles/maternal/nga.pdf)).

<sup>339</sup> WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division Maternal Mortality Estimation Inter-Agency Group, *Maternal Mortality in 1990-2013* (May 2014), p 2.

<sup>340</sup> Home birth co-exists with the conventional maternity delivery, although without operational license. Salako, *The Tradition Birth Attendant And The High Nigeria's Maternal Mortality* (2002) 5(1) *Nigerian Journal of Clinical Practice* 69, at 69, comments: "As traditional birth attendants are continuously being trained for expanded roles in primary health care, the question of legal status and liability becomes more urgent. ... What happens in case of death or injury as a result of negligence, incompetence, omission, or a plain breach of the criminal law as might arise when abortions and female circumcision have been performed."

<sup>341</sup> Mojekwu & Ibekwe, *Maternal Mortality in Nigeria: Examination of Intervention Methods* (2012) 2 *Int'l J of Humanities & Soc Sci* 135, at 146-148.



“[d]uration of schooling was significantly associated with the risk of maternal death . ... Compared with women who had some education, women with no education were more likely to have been unbooked

...<sup>343</sup>  
...

Unbooked emergencies significantly increased the risk of maternal death.<sup>344</sup>

A study of maternal mortality in Plateau State found that above 70% of all maternal deaths occurred in women who lacked literacy<sup>345</sup>. A simple equation applied: the higher the women’s educational level, the less likely that she would die during childbirth<sup>346</sup>. A study<sup>347</sup> of maternal mortality at the Central Hospital, Benin City produced an even more striking finding: 80.7% of the women who died in pregnancy and delivery had had no formal education<sup>348</sup>. Unbooked emergencies led to death 30 times more frequently than for mothers who had booked<sup>349</sup>.

A similar study carried out in North-Central Nigeria<sup>350</sup> found that the maternal mortality rate among unbooked women was about twenty times greater than among women who had had antenatal care<sup>351</sup>.

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<sup>342</sup> Ezeibunwa Nwokocha, *Widowers’ accounts of maternal mortality among women of low socioeconomic status in Nigeria* (2012) 16 *African J of Reproductive Health* 102, at 113-115. The reluctance of husbands or other male partners to be involved in the process of labour and delivery, driven by a traditional belief that this would delay the labour process, contributes to the problem: see Vehvilainen-Julkunen & Emelonye, *Spousal Participation in Labor and Delivery in Nigeria* (2014) 4 *Ann Med Health Sci Res* 511.

<sup>343</sup> Fawole, Shah, Fabanwo, Adegbola, Adewumi, Eniayewun, Dara, El-Ladan, Umezulike, Alu, Adebayo, Obaitan, Onala, Usman, Sullayman, Kailani & Sa’id, *Predictors of maternal mortality in institutional deliveries in Nigeria* (2012) 12(1) *African Health Sciences* 32, at 36.

<sup>344</sup> *Ibid.*

<sup>345</sup> Ujah, Aisien, Mutahir, Vanderjagt, Glew & Uguru, *Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-year Review* (2005) 9 *African J of Reproductive Health* 27, at 32.

<sup>346</sup> *Ibid.* at 37. See also Kelsey Harrison, *The Struggle to Reduce High Maternal Maternity in Nigeria* (2009) 13 *African J of Reproductive Health* 9, at 14.

<sup>347</sup> Abe & Omo-Aghoja, *Maternal Mortality at the Central Hospital, Benin City: A Ten Year Review* (2008) 12 *African J of Reproductive Health* 17.

<sup>348</sup> *Ibid.*, at 19.

<sup>349</sup> *Ibid.*, at 21

<sup>350</sup> Ujah, Aisien, Mutahir, Vanderjagt, Glew, & Uguru, *Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-year Review* (2005) 9 *African J of Reproductive Health* 27.

<sup>351</sup> *Ibid.*, at 31.

Early marriage and teenage pregnancy are associated with increased likelihood of maternal mortality and maternal morbidity, as well as increased likelihood of death for infants within one year after birth.<sup>352</sup> The practice of early marriage is particularly common in the North of Nigeria, where adherence to Islam and a high incidence of poverty combine to encourage marriage by girls at a very young age.<sup>353</sup>

There thus is a major social and cultural dimension to the phenomenon of high maternal mortality in Nigeria. But there are also clear defects in the delivery of healthcare in Nigeria. These defects manifest themselves at the macro level: poor distribution of hospitals, poor structural of primary care and so on. Institutionally, hospitals are often poorly run, understaffed, with poor equipment.

#### (ii) *Infrastructural Deficiencies in Nigerian Maternal Healthcare*

Recent research demonstrates the disturbing realities in Nigerian hospitals. It is important to record in detail the results of this research as it has a strong bearing on how the law of negligence in Nigeria should best be applied to take account of these realities.

A study<sup>354</sup> of the causes of obstetric deaths at the Central Hospital, Benin City found that 16.8% were attributable to "institutional difficulties", which consisted of the lack of a power supply, the lack of blood, delayed referral, delayed decision-making and the mother's inability to pay fees.<sup>355</sup> The hospital had a "policy of

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<sup>352</sup> Obiajulu Nnamuchi, *Millennium Development Goal 5, Human Rights, and Maternal Health in Africa: Possibilities, Constraints, and Future Prospects* (2014) 23 *Annals of Health L* 92, at 102; Tim Braimah, *Child marriage in Northern Nigeria: Section 61 of Part 1 of the 1999 Constitution and the protection of children against child marriage* (2014) 14 *African Human Rts J* 474, at 484.

<sup>353</sup> *Ibid.*, at 102; Tim Braimah, *Child marriage in Northern Nigeria: Section 61 of Part 1 of the 1999 Constitution and the protection of children against child marriage* (2014) 14 *African Human Rts J* 474, at 483-484.

<sup>354</sup> Abe & Omo-Aghoja, *Maternal Mortality at the Central Hospital, Benin City Nigeria: A Ten Year Review* (2008) 12 *African J of Reproductive Health* 17.

<sup>355</sup> *Ibid.*, at 22. Omo-Aghoja, Aisien, Akuse, Bergstrom & Okonofua, *Maternal mortality and emergency obstetric care in Benin City, South-south Nigeria* (2010) 2(4) *J of Clinical Medicine and Research* 55.

‘cash and carry’ as a basis for treatment of patients even in the face of dire emergency”.<sup>356</sup>

The lack of essential medical products is striking. A study<sup>357</sup> of the provision of essential obstetric care in a selected local government area of South-West Nigeria, reported in 2007, found that none of the 21 public health facilities and 5 privately owned health facilities met the criteria for a basic essential obstetric care facility. Parenteral oxytocics were available in only half of the facilities, while parenteral anti-convulsants for the management of hypertensive diseases of pregnancy were available in only 11.5% of the facilities<sup>358</sup>. Intravenous infusion fluids were not available in 77% of the health facilities<sup>359</sup>. Half of the facilities did not have sterile syringes or needles<sup>360</sup> or parenteral antibiotics other than metronidazole<sup>361</sup>.

Women’s experience of medical care during pregnancy and labour is highly negative. A qualitative study<sup>362</sup> of eight women who had experienced conventional maternity service provision in a rural Niger Delta community revealed very significant dissatisfaction. Six of the eight had experienced problems resulting from the scarcity of qualified staff<sup>363</sup>. Three found deficiencies with postnatal service provision<sup>364</sup>, two of whom considered that it scarcely existed<sup>365</sup>. Four criticised the lack of equipment<sup>366</sup>. Three perceived inadequacies in infrastructure of the

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<sup>356</sup> *Ibid.*, at 23.

<sup>357</sup> Ijadunola, Adesegun, Fatusi, Ernest, Orji, Adeyemi, Owolabi, Ojofeitimi, Omideyi & Adewuyi, *Unavailability of Essential Obstetric Care Services in a Local Government Area of South-West Nigeria* (2007) 25 *J of Health Population Nutr* 94.

<sup>358</sup> *Ibid.*, at 97.

<sup>359</sup> *Ibid.*

<sup>360</sup> *Ibid.*

<sup>361</sup> *Ibid.*

<sup>362</sup> Igboanugo & Martin, *What are pregnant women in a rural Niger Delta community’s perceptions of conventional maternity service provision? An exploratory qualitative study* (2011) 15 *African J of Reproductive Health* 59.

<sup>363</sup> Igboanugo & Martin, *What are pregnant women in a rural Niger Delta community’s perceptions of conventional maternity service provision? An exploratory qualitative study* (2011) 15 *African J of Reproductive Health* 59, at 64.

<sup>364</sup> *Ibid.*, at 65.

<sup>365</sup> *Ibid.*

<sup>366</sup> *Ibid.*, at 67.

buildings in which maternity care was delivered<sup>367</sup>. Three participants said that cost deterred some childbearing women from accessing essential care<sup>368</sup>.

The lack of necessary medical equipment is the direct cause of maternal mortality. A study of maternal mortality in Enugu State University Teaching Hospital found that hypertensive disease was the leading cause of death<sup>369</sup>. The researchers report that:

*“[t]he high maternal mortality was common among the unbooked primigravidae who usually present late with eclampsia, coupled with the non-availability of magnesium sulphate in the hospital within the study period; a drug that has been shown to be very effective in the management of severe pre-eclampsia and eclampsia.”<sup>370</sup>*

The study goes on to report that haemorrhage was also a common cause of death<sup>371</sup>. It notes that:

*“[m]ost of these deaths are preventable by the use of oxytocics and anti-shock garments in [the] labour ward and transfusion of adequate compatible blood.”<sup>372</sup>*

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<sup>367</sup> *Ibid.*, at 67-68.

<sup>368</sup> *Ibid.*, at 68. The experience of women in this Nigerian study is strikingly similar to that of women participating in a qualitative study in Benin: see Grossmann-Kendall, Filippi, De Koninck & Kanhonou, *Giving Birth in Maternity Hospitals in Benin: Testimonies of Women* (2001) 9 *Reproductive Health Matters* 90.

<sup>369</sup> Ezugwu, Onah, Ezugwu & Okafor, *Maternal Mortality in a Transitional Hospital in Enugu, South East Nigeria* (2009) 13 *African J of Reproductive Health* 67, at 70. This represented 29.63% of the deaths.

<sup>370</sup> *Ibid.*, at 71 (emphasis added).

<sup>371</sup> Ezugwu, Onah, Ezugwu & Okafor, *Maternal Mortality in a Transitional Hospital in Enugu, South East Nigeria* (2009) 13 *African J of Reproductive Health* 67, at 70. This cause represented 27.78% of the deaths.

<sup>372</sup> *Ibid.*, at 71 (emphasis added). The study does not spell out why so many such preventable deaths were not prevented.

Sepsis was a cause of death in 11.11% of all maternal deaths at the hospital. The researchers observe that:

*“[t]he availability of a wide range of potent antibiotics would have controlled sepsis and prevented death, but unfortunately most of these patients who delivered at home under very unhygienic condition[s] present in septicaemic shock and could not afford potent and effective antibiotics which may be their only saving grace.”<sup>373</sup>*

The lack of blood supplies drives up maternal mortality. A study<sup>374</sup> of the risk factors for maternal deaths in unplanned obstetric admission to an intensive care unit in South Eastern Nigeria found a 67% mortality rate in those women with obstetric haemorrhage<sup>375</sup>. The researchers reported that:

*“[l]imited supply of blood products contributed to the high mortality rate in the obstetric haemorrhage group. Fresh whole blood and*

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<sup>373</sup> *Ibid.*, at 71 (emphasis added). See also Olopade & Lawoyin, *Maternal Mortality in a Nigerian Maternity Hospital* (2008) 12 African J of Biomedical Research 267, reporting on a retrospective case-control study carried out at Adeoyo Maternity Hospital, Ibadan. Sepsis was the cause of 23.8% of the cases of maternal death. The researchers comment (at 271): “*Puerperal sepsis which commonly complicated by anaemia can be adequately managed by aggressive antibiotic administration and blood transfusion when necessary. Patients who are unable to afford these are usually those that die* (emphasis added). A recent study of the incidence of obstetric fistula in Nigeria (Philips, Ononokpono & Udofia, *Complicating Causality: patient and professional perspectives on obstetric fistula in Nigeria* [2016] Culture, Health & Sexuality 1 (<https://dx.doi.org/10.1080/13691058.2016.1148198>)) found that women were attempting to give birth at home to avoid the costs associated with births at health care facilities: “*Healthcare professionals ... shared that hospitals and clinics usually make women pay for anything they might ‘consume’ (such as syringes, scissors, gloves and linen, often termed ‘consumables’ in Nigeria. Many patients also recalled the severe financial constraints related to obtaining obstetric services ... women recalled being asked to pay N10,000 to N100,000 (US\$ 50-500) for surgical procedures to remove their baby. The average income of the fistula patients was N10,000 (\$50) per month*”: *id* at 9. A study of 21 health facilities in three states in Nigeria found that availability of anaesthetics was the only variable independently predictive of maternal death at the health facilities level (rather than at the level of the patient: Fawole, Shah, Fabanwo, Adegbola, Adewunmi, Eniayewun, Dara, El-Ladan, Umezulike, Alu, Adebayo, Obaitan, Onala, Usman, Sullayman, Kailani & Sa’id, *Predictors of maternal mortality in institutional deliveries in Nigeria* (2012) 12(1) African Health Sciences 32, at 39, the researchers report that: “*[o]nly half of all participating health facilities had qualified anaesthiologist who could provide quality intensive care.*”

<sup>374</sup> Okafor, Efetie & Amucheazi, *Risk factors for maternal deaths in unplanned obstetric admissions to the intensive care unit – lessons for Sub-Saharan Africa* (2011) 15 African J of Reproductive Health 51.

<sup>375</sup> *Ibid.*, at 52.

*platelet concentrate that are required in a major coagulopathy were either in short supply or unavailable for emergencies and was a culpable factor in all the obstetric haemorrhage deaths.*”<sup>376</sup>

The inadequacies of care, even in more well-resourced regions of Nigeria, are scandalous. A cross-sectional facility-based survey<sup>377</sup> conducted in 2009 in Gokana local government area in Rivers state, in an oil-rich part of the state found that none of the ten functional primary healthcare facilities performed all of the six “signal functions”<sup>378</sup> required for basic emergency obstetric care in the three months preceding the survey. The researchers report:

*“The services most routinely performed were the administration of parenteral antibiotics (66.7%), parenteral oxytocics (41.7%), parenteral anticonvulsants (33.3%), and manual removal of placenta (33.3%). Only three of the facilities (25%), had performed the removal of retained products of conception, while only two (16.7%) had carried out assisted vaginal delivery. Also only two facilities (16.7%) had transport for emergency referral of clients.”*<sup>379</sup>

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<sup>376</sup> *Ibid.*, at 53. As to delays in the provision of blood, see further Ibeh Christian, *Is poor maternal mortality index in Nigeria a problem of care utilization? A case study of Anambra State* (2008) 12 African J of Reproductive Health 132, at 138.

<sup>377</sup> Mezie-Okoye, Adeniji, Tobin-West & Babatunde, *Status of Emergency Obstetric in a Local Government Area in South-South Nigeria* (2012) 16 African J of Reproductive Health 171.

<sup>378</sup> The six basic services involve (i) the administration of parenteral antibiotics, (ii) the administration of parenteral oxytocin, (iii) the administration of parenteral anticonvulsants for pre-eclampsia and eclampsia, (iv) the manual removal of the placenta, (v) the removal of retained products, and (vi) the performance of assisted vaginal delivery.

<sup>379</sup> Mezie-Okoye, Adeniji, Tobin-West & Babatunde, *Status of Emergency Obstetric in a Local Government Area in South-South Nigeria* (2012) 16 African J of Reproductive Health 171, at 174. The dangers to mothers of an inadequate emergency referral system are also highlighted by Nyango, Mutihir, Laabes, Kigbu & Buba, *Skilled Attendance: The Key Challenges to Progress in Achieving MDG-5 in North Central Nigeria* (2010) 14 African J of Reproductive Health 129, at 135.

There were stark findings in respect of the provision of equipment and medical supplies:

*“About half of the facilities had sutures and a vaginal speculum, while less than half had latex gloves. Only a third ... of the facilities had intravenous fluids and infusion sets. ... [T]wo-third had no functional sterilizers, while a quarter did not have a pair of scissors. Partographs, vacuum extractors and curettes were not available in any of the facilities.”<sup>380</sup>*

Staff shortages were also striking. Only 16.67% of the facilities had the minimum requirement of four or more midwives, 66.67% did not have at least one qualified nurse necessary to meet the recommended 24-hour emergency coverage. 41.7% failed to have at least one midwife and 91.7% failed to have at least one qualified doctor. There were no specialist anaesthetists or obstetricians in either of the two general hospitals that fall within the study<sup>381</sup>.

A study<sup>382</sup> of 21 health facilities in Nigeria, published in 2012, found that inadequate facilities for emergency care led to significant loss of life. The researchers stated:

*“Our findings ... revealed, albeit indirectly, certain deficiencies in the*

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<sup>380</sup> *Ibid.*, at 174. The dangers to mothers of an inadequate emergency referral system are also highlighted by Nyango, Mutihir, Laabes, Kigbu & Buba, *Skilled Attendance: The Key Challenges to Progress in Achieving MDG-5 in North Central Nigeria* (2010) 14 African J of Reproductive Health 129, at 135.

<sup>381</sup> Mezi-Okoye, Adeniji, Tobin-West & Babatunde, *Status of Emergency Obstetric in a Local Government Area in South-South Nigeria* (2012) 16 African J of Reproductive Health 171, at 175.

<sup>382</sup> Fawole, Shah, Fabanwo, Adegbola, Adewunmi, Eniyewun, Dara, El-Ladan, Umezulike, Alu, Adebayo, Obaitan, Onala, Usman, Sullayman, Kailani & Sa'id, *Predictors of maternal mortality in institutional deliveries in Nigeria* (2012) 12 African Health Sciences 32.

*health care system. Previous authors reported that the unbooked mother tended to arrive in moribund condition, reflecting a weak referral system and inadequate facilities for emergency obstetric care. The trend noted in this study whereby the need for intensive care was strongly associated with maternal mortality similarly reflects poor health infrastructure. Only half of all participating health facilities had qualified anaesthesiologists who could provide quality intensive care. The significant association between maternal mortality and lack of anaesthesiologists reinforces this condition.*”<sup>383</sup>

Okaro & Iyoke comment:

*“Lack of functional 24h[our] obstetric services in public health facilities has created gaps in service delivery to the people. ... Unfavourable government policy which insist on payment for maternity services at the point of delivery has tended to drive the poor to ... unskilled birth attendants.*”<sup>384</sup>

It is clear that effective management decisions, sensitive to the financial pressures affecting patients, can save lives. A study of critically ill obstetric patients managed at the intensive care unit of the University of Ilorin Teaching Hospital supported the conclusion that the greater availability of blood and blood products and the policy of deferred payment for treatment of emergency patients in that hospital had

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<sup>383</sup> *Ibid.*, at 39.

<sup>384</sup> Okaro & Iyoke, *The Society of Gynaecology and Obstetric of Nigeria (SOGON) Plan for Sustainable Reduction in Maternal Mortality: A Review* (2010) 14 *African J of Reproductive Health* 139, at 140.



the beneficial effect of reducing maternal mortality for poorer women experiencing post partum haemorrhage<sup>385</sup>.

### *Neonatal Deaths*

The infrastructural weaknesses and resource limitations in the delivery of healthcare that result in high levels of maternal mortality in Nigeria also result in alarming levels of neonatal mortality. Globally, Nigeria ranks second to India in the number of neonatal deaths, with the highest reported number in Africa.<sup>386</sup> The neonatal mortality rate has declined from 49 per 1000 live births in 1990 to 39 in 2011<sup>387</sup>.

A case control study carried out on perinatal deaths in the three major public hospitals in Katsina metropolis<sup>388</sup>, reported in 2014, found significant weaknesses in the delivery of healthcare, attributable in part to infrastructural and resource deficiencies. The perinatal mortality rate was 13% of all births in these hospitals.

The study found that most of the perinatal deaths that followed antepartum haemorrhage were due to placental abruption and presented as stillbirths. The authors comment that:

*“[t]his is very important in our locality because of the high rate of lack on antenatal care and the late presentation to hospital after complication have arisen. The emergency response time is also quite*

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<sup>385</sup> Adeniran, Bolaji, Fawole & Oyedepo, *Predictors of maternal mortality among critically ill obstetric patients* (2015) 27 Malawi Medical Journal 16, at 18. See also Knight, Self & Kennedy, *Why Are Women Dying When They Reach Hospital on Time? A Systematic Review of the "Third Delay"* (2013) 8 PLoS ONE 1, referring to the earlier research of Orji, Ojofeitimi, Esimai, Adejuyigbe *et al*, *Assessment of delays in receiving delivery care at a tertiary healthcare delivery centre in Nigeria* (2006) 26 J Obstet Gynaecol 643, which found that, in that centre, over 20% of the maternal deaths were attributable to delays in acquiring blood.

<sup>386</sup> See Ezeh, Agho, Dibley, Hall & Page, *Determinants of neonatal mortality in Nigeria: from the 2008 demographic and health survey* (2014) 14 BMC Public Health 521, at p 2 of the electronic version.

<sup>387</sup> *Ibid*.

<sup>388</sup> Suleiman & Mokuolu, *Perinatal mortality in a northwestern Nigerian city: a wake up call* (2014) 2 frontiers in Pediatrics 105.

*poor, resulting in needless deaths.*”<sup>389</sup>

The study found that severe perinatal asphyxia was the leading cause of death. It noted that this condition was:

*“... complicated by late referrals of the mothers, sub-optimal monitoring of labor leading to delayed detection of fetal distress and poor emergency response time when emergency delivery is indicated. There is also lack of awareness and skills of neonatal resuscitation among the delivery attendants. This is despite ongoing efforts by non-governmental organizations to train and retrain the healthcare workers in essential newborn care including neonatal resuscitation.”*<sup>390</sup>

This study found that neonatal sepsis was an important cause of perinatal mortality at the hospitals. The authors report:

*“Sepsis thrives when infection prevention steps are not practised by delivery attendants. A very important infection prevention strategy is hand washing before touching a patient and in between patients. This was not routinely practised in any of the delivery rooms where the study was undertaken. This is further compounded by the fact that none of the delivery areas utilized for the study had 24h tap water supply. Water was stored in containers and used for hand washing and other housekeeping procedures that undoubtedly increased the*

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<sup>389</sup> *Ibid.*, at p 6.

<sup>390</sup> Suleiman & Mokuolu, *Perinatal mortality in a northwestern Nigerian city: a wake up call* (2014) 2 *frontiers in Pediatrics* 105., at 6. Not surprisingly, outcomes improve where facilities are of better quality: See Obi, Nkem, Amaka & Chidinma, *Perinatal Mortality in the Private Specialist Hospital Setting in South East Nigeria* (2015) 7 *Archives of Med* 12.

*risk of infection. Another issue noted was none of the facilities has a functional infection control unit. None therefore has an infection control protocol for implementation. There was also no standard operating procedure for identifying and managing babies at risk of infection. All the above could have contributed to infection being an important cause of perinatal death.*<sup>391</sup>

The studies of the causes of neonatal deaths in Nigeria thus corroborate the studies of the causes of maternal mortality: a poor health system, plagued by infrastructural weaknesses, resource limitations, inadequate equipment, poor training and poor performance levels contribute substantially to the high number of deaths of both mothers and infants.

#### *Implication for the Law of Negligence*

What emerges from this empirical research is a picture of official neglect from the highest quarters, coupled with poor standards of health delivery at institutional level.<sup>392</sup> Who is to blame from the standpoint of the law of negligence?

The answer can be provided only by confronting the resources question. One approach for the courts to take would be to have regard to the fact that the Nigerian health system is under-resourced, leading to an inadequate numbers of doctors and nurses, as well as deficiencies in the quantity and quality of medical products. On this approach, it might be considered inappropriate for a court to characterise as negligent the failure of a hospital, doctor or nurse to achieve a standard of care which was impossible to achieve in the light of these resource limitations.

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<sup>391</sup> *Ibid.*

<sup>392</sup> Ibeh Christian, *Is poor maternal mortality index in Nigeria a problem of care utilization? A case study of Anambra State* (2008) 12 African J of Reproductive Health 132, at 138.

On another view, it would be proper for the court to impose liability in such circumstances. Otherwise, the law of negligence would simply be unable to vindicate the rights of patients who were killed or injured by the defective provision of healthcare. If liability is shifted away from the hospital setting, there would be a real danger that no liability would be imposed at all since conventional thinking on the duty of care in negligence litigation is that it is wrong to impose such a duty on public institutions such as governments and ministries in respect of macro decision-making at a high political level.

Perhaps the best course is for the courts to attempt to make the difficult distinction between cases where the deficiency in healthcare is attributable to decisions made above the level of the hospital, at government level, national or regional, and cases where the deficiency is attributable to the hospital authorities themselves.<sup>393</sup>

Certain cases will be clear-cut: for example, there may have been no funding for an obstetrician authorized by the State budget. Other cases will be far less clear. A particular piece of medical equipment or a particular medical product may not have been available when the plaintiff was receiving healthcare in the hospital. The patient may claim that this lack of availability constituted negligence on the part of the hospital, whereas the hospital argues that it did not have sufficient funds to purchase the relevant item.

It is respectfully submitted that, in such circumstances, a court should not be bound by this stance taken by the hospital and should instead examine the budget of the hospital to determine whether the hospital's failure to have the item can be

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<sup>393</sup> I shall argue, later in this thesis that Nigerian courts should extend the scope of the duty of care to embrace even decisions made at a macro level in regard to the provision of health services. Just as courts internationally exercise circumspection when enforcing a justiciable right to health under a national Constitution (as in South Africa, or Kenya, for example), so also courts should exercise their jurisdiction to impose liability in negligence for the breach of the duty of care in a cautious manner, respectful of the separation of powers but not surrendering their entitlement, in egregious cases, to impose such liability.

justified. Obviously, a court should come to the conclusion that such failure was unjustified only in the clearest of cases: hospitals should be given a very broad margin of appreciation in making prioritisations of this kind.

When one reviews the research, however, one encounters such striking deficiencies in the supply of items costing virtually nothing that it seems entirely justified for a court to hold that such failure constitutes negligence. For example, the 25% of the functional primary healthcare facilities in Rivers state<sup>394</sup> that lacked a pair of scissors and the 50% of them that lacked latex gloves should not be permitted to argue that these deficiencies were attributable to resource constraints. There comes a point where the plea of resource constraints should not fall on deaf judicial ears.

### *The Caselaw in Nigeria and Other African States*

Let us now turn to consider briefly the caselaw on the subject.

Astoundingly, there has been no reported decision in Nigeria imposing liability on nurses, doctors, hospitals, officials, ministries or the government for the failure to provide safe obstetric care. The only known cases involve criminal prosecutions rather than civil claims. In *Olowu v The Nigerian Navy*,<sup>395</sup> the plaintiff was charged to General Court Martial for negligence as obstetrician/gynaecologist in the care and management of his patient. The attending nurse who conducted a preliminary test discovered meconium stains which indicated complications. As a result, she sent for the doctor and informed him that the condition of the patient required urgent attention. The plaintiff asked the attending nurse questions, but failed to examine the patient himself and left the medical centre. He returned the following morning, by which time the patient's condition had deteriorated. He merely wrote a letter of referral to the military hospital. The patient was bleeding seriously at the

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<sup>394</sup> Mezi-Okoye, Adeniji, Tobin-West & Babatunde, *Status of Emergency Obstetric Care in a Local Area in South-South Nigeria* (2012) 16 African J of Reproductive Health 171, at 174.

<sup>395</sup> 9 December 2011 (SC).

time. At the military hospital it was discovered that her baby had died twenty hours previously and that the patient's uterus had ruptured. She therefore was unable to have any more children.

The court martial convicted the plaintiff and found him guilty on a charge of negligence, which the appellate courts affirmed.

In a similar case, it was reported in *Olaye v Chairman, Medical and Dental Practitioners Investigation Panel*,<sup>396</sup> that “physicians failed to give prompt medical attention to a pregnant woman who had a ruptured ectopic pregnancy until 36 hours later, the tribunal found the five physicians, including two consultants, who were responsible for neglect guilty of negligence”<sup>397</sup>.

There has been a small volume of civil litigation relating to obstetric negligence in other African states that has resulted in a judgment.

In *Watsemwa & Anor v Attorney General*,<sup>398</sup> Musoke J of the High Court of Uganda held the rupturing of the membrane while the cervix was still at 6 centimetres constituted negligence. The midwife had not consulted the obstetrician before doing so and she had not been called as a witness by the defendant to clarify the position. This, in Musoke J's view, “left a big gap, to the disadvantage of the defendant”. The failure by the midwife to have taken notes of the progress of the labour upon indecision had exacerbated the defendant, constituting “negligence of the highest order”.

In *Semenye v Aga Khan Hospital & Ors*,<sup>399</sup> a baby delivered at the defendant hospital sustained Erbs Palsy, a condition resulting from the manner of his birth. The baby was large, and the doctor had to engage in manoeuvres to pull him out of

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<sup>396</sup> (1997) 5 NWLR (Pt. 506) 55 CA.

<sup>397</sup> Iyioha & Nwabueze eds, *Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law* (Ashgate Publishing Ltd, 2015), at 75.

<sup>398</sup> [2015] UGHCCD 16.

<sup>399</sup> [2006] eKLR.

his mother's womb when his shoulder had become stuck. The essence of the claim for negligence was that better and more expeditious care should have been afforded the mother and baby during labour, that a caesarean section should have been contemplated<sup>400</sup> and that the doctor was not up to the task of removing the child safely.

Ang'awa J, of the Kenyan High Court, imposed liability, on the basis of the delay of ten minutes before the doctor arrived, having been called by the midwife, and on the basis of his inexperience. As regards the latter matter, the doctor was a qualified physician and a senior house doctor, studying for his Masters degree in Obstetric & Gynaecology and pursuing a Fellowship with the Royal College of Obstetrician & Gynaecologist. At the time of the birth of the plaintiff, he had four years' experience as a doctor. He had delivered many babies but had never previously experienced the type of delivery that presented itself. Ang'awa J imposed liability on the basis that the doctor "was a specialist gynaecologist and thus [was] not capable of dealing with such emergency"<sup>401</sup>. Thus conclusion is somewhat hard to justify. There was no evidence that the condition was so distinctively challenging as to be beyond the doctor's competence.

In *Lushaba v MEC for Health, Gauteng*,<sup>402</sup> liability was imposed on a hospital for the failure of its medical staff to respond appropriately and with due expedition when a woman, 36 weeks pregnant, presented herself at the maternity obstetrician unit with constant pain in her abdomen, demonstrating symptoms indicative of abruptio placentae. This condition placed her unborn child in danger of being deprived of oxygen. Delivery by caesarean section was thus essential but was delayed for two hours, resulting in the baby's suffering cerebral palsy.

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<sup>400</sup> *Semenye v Aga Khan Hospital & Ors* [2006] eKLR. Rather than what Ang'awa J described as "virgina" birth.

<sup>401</sup> *Ibid.*, at para 78.

<sup>402</sup> [2015] ZAGPJHC 13

In *Hilda Atieno Were v Board of Trustees Aga Khan Hospital*,<sup>403</sup> the plaintiff sought damages against the hospital on the basis that it had put her through an unnecessary operation to remove an ovarian cystic mass whereas in fact all that she suffered from was constipation. A radiologist working for the hospital had made the diagnosis of ovarian cystic mass.

Ali-Aroni J imposed liability. The judge noted that the gynaecologist had acknowledged that a radiological opinion might be erroneous and commented:

*“Although armed with this knowledge [the gynaecologist] did not seek another opinion or conduct any other test. ... If this is not a case of extreme negligence, what could it be?”*

Liability was accordingly imposed on the hospital both in respect of the radiologist’s negligence and the gynaecologist’s negligence.

In *Buthelezi v Ndaba*,<sup>404</sup> the plaintiff suffered from a vesico-vaginal fistula following a hysterectomy carried out by the defendant, a specialist gynaecologist and obstetrician. The defendant had no recollection of the operation. The trial judge imposed liability but the South African Supreme Court of Appeal reversed. The Court was impressed by evidence that, even when carried out with due care, a hysterectomy operation might have such an unfortunate outcome and that inadvertent bladder injury might be caused even with careful surgical technique<sup>405</sup>.

The courts have on a number of occasions dismissed claims for obstetric negligence on the basis that the medical personnel had not acted negligently.

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<sup>403</sup> [2011] eKLR.

<sup>404</sup> [2013] ZASCA 72.

<sup>405</sup> *Ibid.*, at para 13.



In *Mosheti v Attorney General*,<sup>406</sup> the Botswana Court of Appeal upheld the dismissal of a claim for professional negligence against the medical staff of a hospital where the plaintiff's unborn child died during labour. The central allegation was that the staff had failed to detect foetal distress in time. Expert evidence was adduced on behalf of the plaintiff to the effect that, while monitoring had occurred, it should have been carried out more intensively. Steyn JA observed:

*“[T]he obstetrician in charge at 7.30am ... could find no evidence of distress or abnormality which required intervention. Neither did either the experienced nursing sister on duty at admission, or the general practitioner who examined the plaintiff shortly after admission. Moreover, it was never seriously contended in evidence that the monitoring ... as reflected on the medical records was inadequate or defective. It is also essentially speculative to hold that more intensive monitoring would as a matter of probability have saved the foetus.”*

## 2. Wrongful Birth and Wrongful Life

The claims for "wrongful birth" of a healthy or disabled child taken by healthy or disabled parents and "wrongful life",<sup>407</sup> taken by a child against medical practitioners are recent developments in medical negligence jurisprudence. Their legal requirements are determined by the general principles of tort law, but inevitably the prevailing views within the courts across the jurisdictions turn to the moral questions in which policy considerations loom large.

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<sup>406</sup> [1998] Botswana LR 20 (CA).

<sup>407</sup> Kelly E. Rhinehart, *The Debate Over Wrongful Birth and Wrongful Life* (2002) 26 Law & Psychol. Rev 141, at 155-156, stated: "Wrongful life is a legal cause of action in which a congenitally-diseased child sues the doctor, claiming that but for the negligence of the doctor, the child would not have been born into a life of pain and suffering."

In a claim for wrongful birth, where the mother or both parents complain for example, that a botched sterilisation resulted in the birth of an unplanned child, courts have taken different approaches regarding recovery on different heads of damages. The first allows full recovery without offset – upbringing and pregnancy costs irrespective of the health status of the child.<sup>408</sup> The second allows full recovery with offset – upbringing costs, weighed against the benefits the child will bring.<sup>409</sup> The third allows recovery for pregnancy and additional disability costs where either the child or mother is disabled.<sup>410</sup> The fourth allows “pregnancy costs only” whether or not the child is disabled.<sup>411</sup> The last approach denies recovery for either pregnancy or upbringing costs.<sup>412</sup>

In a claim for wrongful life, the child may, for example, have been born disabled, where the child’s mother had wrongful sterilisation or an abortion. The child argues that his or her very existence is “wrongful”, in the sense that the child’s life has been so blighted by injury or disability that it would have been preferable that he or she not have come into existence. Clearly, the philosophical and ethical issues here are formidable. In these cases; somewhat similar to the wrongful birth litigation, there are three approaches to recovery. The first approach allows recovery of general damages – pain, suffering, and disability costs.<sup>413</sup> The second approach allows special damages, which includes medical costs,<sup>414</sup> while the last approach denies recovery completely on the basis of lack of legally cognizable injury.<sup>415</sup>

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<sup>408</sup> *Cattanach v Melchior* (2003) 215 CLR 1.

<sup>409</sup> *Udale v Bloomsbury Area Health Authority* [1983] 1 WLR 1098.

<sup>410</sup> *Emeh v Kensington and Chelsea and Westminster Area Health Authority* [1985] 1 QB 1012.

<sup>411</sup> *McFarlane v Tayside Health Authority* [2000] 2 AC 59.

<sup>412</sup> *Rees v Darlington Memorial Hospital NHS Trust* [2004] 1 AC 309.

<sup>413</sup> *Curlender v Bio-Science Laboratories* (1980) 106 Cal. App. 3d 811.

<sup>414</sup> *Turpin v Sortini* (1982) 31 Cal.3d 220.

<sup>415</sup> *McKay v Essex Area Health Authority* [1982] 1 QB 1166; *Harriton v Stephens* (2006) 226 CLR 52. McMahon & Binchy, *Law of Torts* (4<sup>th</sup> ed, Bloomsbury professional 2013), para 33.51: “Let us now consider the developing law on claims for ‘wrongful birth’ and ‘wrongful life’. This subject can best be understood in the light of changes internationally in science, technology and culture. Formerly, life tended to be regarded with awe, most generally expressed in religious or quasi-religious terms. Abortion, euthanasia and suicide were considered violative of the obligation resting on everyone to respect the right to life. Social attitudes, backed by law, sought to channel the

The influence of a state's constitutional norms on this subject can be considerable. In the United States of America, the Supreme Court, in *Roe v Wade*<sup>416</sup> held that a pregnant woman had a constitutional right of access to abortion as an aspect of her right to privacy.

After *Roe v Wade*,<sup>417</sup> courts in the United States generally became willing to recognise claims for wrongful birth claims arising from the negligence of doctors who failed to diagnose or inform the mother of the child's potential abnormality<sup>418</sup>.

The Supreme Court of Canada in *Arndt v Smith*,<sup>419</sup> like courts in the United States of America, was influenced by Canada's very clinical abortion law when holding that a woman who had not been informed of the risks associated with contracting chickenpox during pregnancy was entitled to compensation for the interference with her right to abort the unborn child.

In the United Kingdom, where there has been clinical abortion since 1967, courts were for many years willing to award damages for upbringing costs associated with the birth of a child conceived as a result of medical negligence, most frequently in cases of failed sterilisation.

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creation and rearing of children into the model of lifelong marriage. Today, the international picture is quite different. Against the backdrop of reduced adherence to religious values and a greater emphasis on individualised norms of autonomy and privacy, there is widespread legalised access to abortion and contraception; assisted human reproduction involves the creation of embryos outside the womb, as well as previously unimaginable processes of gestational surrogacy, backed by pre-implantation genetic testing."

<sup>416</sup> (1973) 410 U.S. 113, the United States Supreme Court stated the circumstances in which the woman's right to abortion and the State's right to protect *potential* life, held thus: (a) at 150, that a foetus is not a person but "*potential*" life is involved; (b) at 153, the right of privacy is broad enough to encompass a woman's decision whether or not to terminate her pregnancy, (c) at 163, for the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician, (d) at 163, for the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health, (e) at 163-164, for the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

<sup>417</sup> *Ibid.*

<sup>418</sup> See (eg) *Becker v Schwartz* (1978) 46 NY 2d 401; *Greco v United States* (1995) 893 P.2d 345, *Bader v Johnson* (1997) 675 NE 2d 1119.

<sup>419</sup> [1997] 2 SCR 539.

The House of Lords in *McFarlane v Tayside Health Board*<sup>420</sup> reversed this policy, though in *Rees v Darlington Memorial Hospital NHS Trust*,<sup>421</sup> it modified its stance to authorise compensation where the mother was disabled.

The High Court of Australia in *Cattanach v Mechior*<sup>422</sup> took a different view from that of the House of Lords in *McFarlane*<sup>423</sup>, holding that parents could be compensated for upbringing costs of the child. It is not very easy to identify the cultural and social reasons for this differing approach. Australian society is somewhat less conservative than British society, but Australian judges are not noticeably more liberal than their British counterparts.

In Ireland, in *Byrne v Ryan*,<sup>424</sup> Kelly J denied compensation for child-rearing expenses, having regard to Article 40.3.3 of the Constitution.

The court allowed recovery for pain, suffering and inconvenience during pregnancy and childbirth (which had actually been conceded by the defendant). Kelly J stated:

*“I am also of opinion that the conclusion which I have arrived at blends more harmoniously with the constitutional order which obtains in this jurisdiction than would a decision to the contrary. The value which the Constitution places upon the family, the dignity and protection which it affords to human life are matters which are, in my view, better served by a decision to deny rather than allow damages of the type claimed.”*<sup>425</sup>

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<sup>420</sup> [2000] 2 AC 59.

<sup>421</sup> [2004] 1 AC 309.

<sup>422</sup> (2003) 215 CLR 1.

<sup>423</sup> *McFarlane v Tayside Health authority* [2000] 2 AC 59.

<sup>424</sup> [2009] 4 IR 542.

<sup>425</sup> *Byrne v Ryan* [2004] 4 IR 542. Cf the decision of the Supreme Court of Appeal, South Africa in the case of *Stewart v Botha* [2008] ZASCA 84, at para 23-28.

In contrast to actions for wrongful birth, actions for wrongful life have generally been rejected.<sup>426</sup> They are not available in the United Kingdom, Ireland, most states of the United States of America, Canada or Australia. This is because the existential and normative stakes are far higher than in actions for wrongful birth. The plaintiff in a wrongful life action is asserting, in effect, that his or her very existence constitutes an injury and that it would have been better for him or her never to have existed.

In South Africa, the position is in the process of change. Formerly, there was opposition to the action for wrongful life. In *Stewart & Anor v Botha & Anor*.<sup>427</sup> The plaintiffs' child was born with severe congenital defects following the negligent conduct of the defendant whom the mother consulted during her pregnancy failed to inform her of congenital defects in the foetus she was carrying, alleged that she would have undergone a termination of pregnancy and consequently the child would not have been born. Snyders AJA concluded:

*“The essential question that is asked when enquiring into wrongfulness for purposes of delictual liability is whether the law should recognise an action for damages caused by negligent conduct and that is the question that falls to be answered in this case. ... whatever perspective one views the matter the essential question that a court will be called upon to answer ... is whether the particular child should have been born at all. That is a question that goes so deeply to the heart of what it is to be human that it should not even be asked of*

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<sup>426</sup> Frati, Fineschi, Di Sanzo, La Russa, Scopetti, Severi & Turillazzi, *Preimplantation and Prenatal Diagnosis, Wrongful Birth and Wrongful Life: A Global View of Bioethical and Legal Controversies* (2017) 23 Human Reproduction Update 338, at 346-348.

<sup>427</sup> [2008] ZASCA 84.

*the law.*"<sup>428</sup>

In the later case of *H v Fetal Assessment Centre*,<sup>429</sup> however, the Constitutional Court of South Africa expressed its willingness to contemplate recovery of damages for "wrongful life", which it reformulated as a "wrongful suffering" claim by a child, laying emphasis on the constitutional and statutory provisions which expressly protect the best interest of the child<sup>430</sup>. The plaintiff was born with Down syndrome and suffered other congenital defects requiring dependence and continuing caring. The plaintiff alleged the defendant had failed to warn the mother of the high risk of the child being born with Down syndrome. The Constitutional Court considered the viability of the cause of action without deciding the merits of the claim but it took the position that the courts should be permitted to consider whether the common law might develop to recognise the claim<sup>431</sup>. The Court set aside the decision of the trial court and ordered retrial. It acknowledged that a child's claim might potentially be found to exist<sup>432</sup>. Froneman J stated:

*"Whether it does so exist and in what form, needs to be decided ...  
within our constitutional imperative that the decision must accord*

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<sup>428</sup> *Stewart & Anor v Botha & Anor* [2008] ZASCA 84, at para 28.

<sup>429</sup> [2014] ZASCA 34.

<sup>430</sup> Froneman J noted (at para 69): "Under the Constitution children have the right to have their best interests be given paramount importance in every matter concerning them. That includes a pre-natal medical expert misdiagnosis that results in the child being born with a disability. When parents do not claim for the medical expenses in those circumstances, as they are entitled to, the choice is to let loss lie with the child or to burden the medical experts with the loss that they would have been legally liable for to the parents anyway. A conceivable option is that the best interests of the child may require that the loss should not in those circumstances lie with the child. Translated into legal terms, that would mean that there may be a legal duty not to cause that loss. Failure to do so might breach that duty and infringe the child's right under section 28(2) of the Constitution."

<sup>431</sup> *Cf: H v Fetal Assessment Centre* [2014] ZASCA 34, at para 49: "That our law, including our common law, must conform to the values of the Constitution and that its development must promote the 'spirit, purport and objects of the Bill of Rights' is the given starting point for determining the viability of the child's claim in the circumstances of this case. The particular values and rights that are at the forefront are those of equality, dignity and the right of children to have their best interests considered of paramount importance in every matter concerning them."

<sup>432</sup> *Ibid.*, at para 81.

*with constitutional rights and values, which must include considering the best interests of the child. This also applies to any other manner in which the claim may be reformulated.*”<sup>433</sup>

### *Implications for Nigerian Law*

How would Nigerian courts respond to the developing jurisprudence on wrongful birth and wrongful life? The answer is by no means clear. On one approach, it may be argued that Nigerian culture is strongly pro-natalist and still generally unreceptive to a consumerist philosophy. The birth of a child, even when not anticipated and the result of negligent healthcare (such as a failed sterilisation) may be regarded not as an injury, but as a blessing. One Nigerian commentator has observed that:

*“[t]he explanation for th[e dearth of cases in Nigeria on the subject] may be deduced from the cultural and religious precepts of the majority that generally consider every life to be a gift.”*<sup>434</sup>

On another approach, it may be argued that the victims of negligent healthcare should not be deprived of a remedy by reason of such broad philosophical considerations which the victims do not necessarily share. Indeed, the fact that they have sued for compensation is a clear demonstration that they do not have a philosophical or moral objection to compensation being awarded. Moreover, the very poor level of maternal and neo-natal healthcare in Nigeria may be considered a reason for imposing liability in cases of proven negligence rather than for creating a barrier to compensation on somewhat amorphous and debatable grounds.

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<sup>433</sup> *Ibid.*

<sup>434</sup> Iyioha, “Medical Negligence”, Chapter 4 of Iyioha & Nwabueze eds, *Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law* (2016).

Perhaps the approach most congenial to Nigerian culture would be for the courts to recognise the action for wrongful birth but limit compensation (as in Ireland) to damages (general and special) directly related to the pregnancy and labour. Claims for wrongful life would appear to be out of harmony with the Nigerian cultural approach to the value of unborn life.

Accordingly, in the concluding chapter, where I set out draft legislative proposals for medical negligence litigation in Nigeria, I propose provisions in line with this approach.

### *3. Psychiatric Negligence*

#### *Introduction: The Cultural Context of Nigerian Understanding of Mental Illness*

In this section, I consider psychiatric negligence in Nigeria. The subject presents huge challenges of a cultural and social kind, which render the type of analysis of the issue that is presented in caselaw in Britain, Australia and North America unhelpful to consideration of the issue in the Nigerian context.

The first point of difference is the cultural understanding of mental illness in Nigeria. Of course there are significant differences of emphasis within the Nigerian community based on education, urbanisation and social class but it is still the case that in Nigeria mental illness is generally perceived as having spiritual rather than physical, neurological or environmental causes. Recourse is, in the main, had to a traditional healer or religious authority figure rather than a psychiatrist.



### *The State of Psychiatry in Nigeria*

Psychiatry is a largely undeveloped discipline in Nigeria. There are around 200 psychiatrists for a Nigerian population of around 167 million.<sup>435</sup>

The "brain drain" of psychiatrists from Nigeria has had a serious effect on the quality of mental healthcare in Nigeria. It has been reported that the training of psychiatrists within Nigeria has been affected by the small numbers of trainers:

*“Even though Nigeria has had home-based specialist training programmes in psychiatry for over 25 years, the rate of production of specialists has remained stunted, and currently only about 50% of Nigeria’s tertiary mental health facilities have enough psychiatrists on their staff to be able to provide accredited training. If Nigerian-trained psychiatrists living overseas were to return to work in Nigeria, the country could probably double its mental health manpower every 5-6 years.”<sup>436</sup>*

The same study reported that:

*“Nigeria’s plan to integrate the delivery of mental health service into primary care has failed because of the shortage of psychiatrists. Only 19 of Nigeria’s 36 states as well as the national capital, Abuja, have*

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<sup>435</sup> See Gureje, Abdulmalik, Kola, Musa, Yasamy & Adebayo, *Integrating mental health into primary care in Nigeria: report of a demonstration project using mental health gap action programme intervention guide* (2015) 15 BMC Health Services Research 242, at 243; Iheanacho, Obiefune, Ezeanolue, Ogedegbe, Nwanyanwu, Ehiri, Ohaeri & Ezeanolue, *Integrating mental health screening into routine community maternal and child health activity: experience from Prevention of Mother-to-child HIV transmission (PMTCT) trial in Nigeria* (2015) 50 Soc Psychiatry & Psychiatric Epidemiology 489, at 490.

<sup>436</sup> Jenkins, Kydd, Mullen, Thompson, Scullery, Kuper, Carroll, Gureje, Hatcher, Brownie, Carroll, Hollins & Wong, *International Migration of Doctors, and Its Impact on Availability of Psychiatrists in Low and Middle Income Countries* (2010) 5(2) PloS ONE 1, at 8.

*any psychiatrists at all.*”<sup>437</sup>

As long ago as 1991, Nigeria adopted the policy of seeking to integrate mental health into primary healthcare.<sup>438</sup> However, researchers recently observed that:

*“the reality is that, to date, little or no mental health care has been offered in primary care settings in Nigeria. A major reason for this discordance between policy intention and real life is the lack of adequate training for primary [health]care providers in the country.”*<sup>439</sup>

There is no clearly defined budget allocation for mental health in the national health budget.<sup>440</sup> Estimates show that around 3.3% of the annual health budget is spent on large, institution based services provided through eight mental hospitals, all located in major cities and disproportionately distributed across the country<sup>441</sup>. Thus, for example, the specialist neuropsychiatric facility located in the North Eastern region of Nigeria is the only health facility that provides mental health services to the 18.9 million people living in the region<sup>442</sup>.

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<sup>437</sup> *Ibid.*

<sup>438</sup> Federal Ministry of Health, *National Mental Health Programme and Action Plan* (1991). For a detailed analysis of the study of mental healthcare, and associated litigation, in Nigeria, see Hudson Westbrook, *Mental Health Legislation and Involuntary Commitment in Nigeria: A Call for Reform* (2011) 10 Washington U Global Stud L Rev 397.

<sup>439</sup> Makanjuola, Doku, Jenkins & Gureje, *Impact of a One-week Intensive 'Training of Trainers' Workshop for Community Health Workers in South-West Nigeria* (2012) 9 Mental Health in Fam Med 25.

<sup>440</sup> Abdulmalik, Kola, Fadahunsi, Adebayo, Yasamy, Musa & Gureje, *Country Contextualization of the Mental Health Gap Action Programme Intervention Guide: A Case Study from Nigeria* (2013) 10(8) PLOS Med 1, at 2. The position of psychiatric nursing care in Nigeria is inhibited by a range of factors, including lack of power within the Ministry of Health, lack of in-service training and lack of resources: see Solomon Musa Gimba, *Barriers to Provision of Psychiatric Nursing Care: A Case Study of a Teaching Hospital, Nigeria* (Dissertation for the Master of Science in Nursing, University of Cape Town, August 2014) p 13.

<sup>441</sup> Abdulmalik, Kola, Fadahunsi, Adebayo, Yasamy, Musa & Gureje, *Country Contextualization of the Mental Health Gap Action Programme Intervention Guide: A Case Study from Nigeria* (2013) 10(8) PLOS Med 1, at 2.

<sup>442</sup> *Ibid.*

In Nigeria, it is reported that “only 20% of people with serious common mental disorders received treatment in the preceding 12 months, and this treatment was mostly below the standards for minimally adequate care”<sup>443</sup>.

There is clear empirical evidence that mental illness is being missed by the medical profession when treating patients for other causes. A study<sup>444</sup> of patients attending the medical out-patient unit of the State university Teaching Hospital at Ado-Ekiti; found that 47.8% had significant depressive symptoms, over 15% of whom had symptoms characterised as either moderately severe or severe. Those attending with respiratory tract disorders were particularly prone to depression: 76.2% were affected by it. Yet in no case did the attending physician refer to depression in his or her primary diagnosis.

The failure of people with mental illness to keep appointments to attend clinics or hospitals has been widely recorded. A recent study notes that “[i]t is generally accepted that twice as many patients miss appointments in psychiatry compared with patients in other specialities”<sup>445</sup>. That study found that 32.6% of patients missed their scheduled first clinic appointment at outpatient clinics in Benin City. Among the several reasons for such defences that it identified was the lack of finances to come to the hospital<sup>446</sup>.

### *Caselaw in Nigeria and Other African States*

There appears to be no decision in Nigeria in which a court has addressed the question of psychiatric negligence. There are few enough decisions in other African

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<sup>443</sup> *Ibid.*

<sup>444</sup> Obadeji, Oluwole, Dada, Ajiboye, Kumolalo & Solomon, *Assessment of Depression in a Primary Care Setting in Nigeria using the PHQ-9* (2015) 4 J of Family Med & Primary Care 30.

<sup>445</sup> Akhigbe, Morakinyo, Lawani, James & Omoaregba, *Prevalence and Correlates of Missed First Appointments among Outpatients at a Psychiatric Hospital in Nigeria* (2014) 4(5) *Annals Med Health Sci Res* 763 [serial online] <http://www.amhsr.org/text.asp?2014/4/5/763/141550>.

<sup>446</sup> *Ibid.*, 766.

countries. The reasons include the fact that, sadly, many of those hospitalised in mental institutions are destitute and often no longer connected with their families.<sup>447</sup> In practice, the scrutiny of professional conduct in mental institutions is very limited, so errors are unlikely to emerge.

In the following two cases, a finding of negligence was made in relation to a mentally ill plaintiff, not in respect of the psychiatric care afforded the patient, but rather on account of a breach of duty of care in which the mental illness was a background factor.

In the Kenyan decision of *Leah Wambui Githuthu v Attorney General & Anor*,<sup>448</sup> a patient who had been admitted four weeks previously to a mental hospital run by the Ministry of Health after a "psychotic episode", had her eyes gouged out when attacked at night by another patient, whose violent disposition must have been known to the nurses. The plaintiff was sleeping in a side-room, isolated from the other patients. She had been given medication which made her weak and drowsy. The door to her side-room had been left open. At the time of the attack, doctors in the hospital had joined a national strike and only the medical superintendent and his deputy were on duty. The defendant sought to avoid liability on the basis that there had never been such an incident previously at the hospital and the attack was unforeseeable. Waki J did not agree and imposed liability. It appears that the previously known violent character of the attacker and the defenceless, unsupervised position in which the plaintiff had been left were the reasons for imposing liability. Waki J stated:

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<sup>447</sup> The African Commission on Human Rights, in *Purohit v Gambia* (2003) AHRLR 96, was aware of this reality. It stated (in para 53): "*The category of persons that would be detained as voluntary or involuntary patients ... are likely to be people picked up from the streets or people from poor background. In cases such as this, the African Commission believes that the general provisions in law that would permit anybody injured by another person's act [to take legal action] can only be available to the wealthy and those that can afford the services of private counsel.*"

<sup>448</sup> [2005] eKLR.

*“The mental institution, the doctors and nursing staff manning it owed [the plaintiff] a duty of care. Indeed, considering the diagnosis they made of her condition, they owed her a special duty of care. ... The nurses must have known about this and should have taken extra precaution to ensure no harm visited [the plaintiff].”*

In *Moga v Nairobi Women’s Hospital & Ors*,<sup>449</sup> another Kenyan decision, a patient with a history of depression died of a pulmonary thrombo-embolism having been admitted to the defendants’ hospital and treated there by a number of doctors. The mistake made successively by the ear, nose and throat surgeon and the psychiatrist was to regard the plaintiff’s symptoms as manifestations of mental illness, without sufficient consideration of the possibility that their source was physical in character. As a result, the patient died. Ougo J imposed liability. With regard to the psychiatric, the position was that she had interviewed the deceased’s relatives on her mental condition and on observation had found that the patient was very sick, propped up in bed, laboured in breathing and was “talking about three people with overalls visiting her and forcing her to iron”. Despite finding the patient as she did, the psychiatrist had opted to administer treatment on depression. Her impression was that the patient was depressed and had bronchospasm. She prescribed aminophylline to treat the bronchi and decongest her chest and two 10mg doses of diazepam, a drug designed to sedate the patient, each dose being administered successively in her presence. The patient died an hour later. Ougo J found that the psychiatrist had been negligent in two principal respects. First, diazepam was a drug that, if appropriate to administer at all, would involve a dose of 5mg/min when starting, with an addition of 10mg/min after four hours, whereas the

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<sup>449</sup> [2015] eKLR.

psychiatrist had prescribed the immediate administration of 20mg. Secondly, the drug should not have been used to sedate a patient with breathing problems.

### *Proposed Way Forward for Psychiatric Negligence Law in Nigeria*

If one looks to the future and considers how Nigerian courts could best develop the principles of the law of negligence in the context of psychiatric care, several challenges need to be confronted. They include (i) the shortage of psychiatrists practicing in Nigeria, (ii) the neglect of psychiatric care at governmental level, (iii) the poor quality of psychiatric care and (iv) the widespread cultural understanding of mental illness as being the result of divine intervention or sorcery. Courts cannot be expected to resolve all of these challenges through the medium of negligence law. They can undoubtedly impose liability for negligence in diagnosis and treatment but some of the other challenges – notably, macro infrastructural weakness, shortage of psychiatrists – are beyond their competence in negligence adjudication. (The possibility of constitutional challenges based on the right to health or of human rights challenges before the African Court on Human and Peoples' Rights or UN monitoring bodies should also be acknowledged).

Cultural aspects present a particular challenge for the courts. One approach would be for courts to adopt an international secular stance and treat cultural attitudes that consider mental illness as being of divine or diabolic origin as simply irrational. The implications for psychiatric practice are, however, formidable. If this approach were adopted, would psychiatrists be obliged to inform their patients that any such beliefs are untrue? Would psychiatrists be under an obligation to ensure that their patients did not resort to practitioners of religion or of traditional medicine?

At present there is an uneasy truce between modern psychiatry and cultural attitudes. If that truce were broken, the consequences could well be detrimental to the interests of the mentally ill.

#### 4. Nursing Negligence

##### *Introduction: The State of Nursing in Nigeria*

In this section, I examine the law's approach to the issue of nursing negligence in Nigeria. First it is necessary to place the subject in its social framework.

Nurses in Nigeria are generally educated to diploma level, acquired after three years of post-secondary – school training, combined with eighteen months of on-the-ground training to become duly certified nurse midwives.<sup>450</sup> Higher level qualifications at bachelors and masters levels, are also available and a far smaller number of nurses reach doctorate level.

Continuing professional education is available in Nigeria but nurses report dissatisfaction with its delivery. A study carried out in public hospitals in Calabar found that less than 1% of nurses considered that issues bordering on patient safety had been adequately addressed<sup>451</sup>. Only a small number of nurses in Nigeria are accessing online continuing professional education “because of lack of expertise in online modules and challenges with power supply”<sup>452</sup>.

Nurses working in Sub-Saharan Africa have more extensive patient care responsibilities on account of the scarcity of doctors in the region.<sup>453</sup> In Nigeria, nurses and midwives account for more than 38% of healthcare workers<sup>454</sup>. Because of the scarcity of physicians, nurses often function as the only healthcare professionals in rural, primary healthcare facilities.<sup>455</sup>

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<sup>450</sup> Ogbolu, Johantgen, Zhu, & Johnson, *Nurse reported patient safety in low-resource settings: a cross-sectional study of MNCH nurses in Nigeria* (2015) 28 *Applied Nursing Research* 341, at 342.

<sup>451</sup> Nsemo, John, Etifit, Mgbekem & Oyira, *Clinical nurses' perception of continuing professional education as a tool for quality service delivery in public hospitals Calabar, Cross Rivers State, Nigeria* (2013) 13 *Nursing Education in Practice* 328, at 331.

<sup>452</sup> *Ibid.*, at 333.

<sup>453</sup> Ogbolu, Johantgen, Zhu & Johnson, *Nurse reported patient safety in low-resource settings: a cross-sectional study of MNCH nurses in Nigeria* (2015) 28 *Applied Nursing Research* 341, at 341.

<sup>454</sup> *Ibid.*, at 342.

<sup>455</sup> *Ibid.*

The non-availability of doctors was identified as a factor in burnout among nurses in a study carried out at the State Hospital in Ibadan, capital of Oyo state.<sup>456</sup> The researchers note that this is a factor suggesting the need for organisational restructuring of the health services of Oyo State:

*“These issues are of utmost ethical import taking into consideration fatigue-related errors [to which] such employees working in these kind[s] of demanding schedules may be liable. Such errors could have serious and adverse repercussions for public safety”.*<sup>457</sup>

There is a proven connection between high numbers of patients and low levels of patient safety. A 2015 study of 140 public health facilities in Nigeria found that:

*“When a nurse cared for less than 13 patients 78% reported patient safety as excellent or good, compared to 65% of nurses who cared for greater than 20 patients. The largest proportion of nurses reporting patient safety as poor/fair (34.5%) were nurses who cared for greater than twenty patients”.*<sup>458</sup>

Reports of the conduct of nurses in Nigeria give cause for concern. A number of the department of nursing at the University of Ibadan recorded in 2013 that:

*“[E]xperience in Nigeria has shown that nurses in the health institutions ... behave as if they are above the law and carry out*

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<sup>456</sup> Lasebikan & Oyetunde, *Burnout among Nurses in a Nigerian General Hospital: Prevalence and Associated Factors* (2012) Int'l Scholarly Research Network, Article ID 402157.

<sup>457</sup> *Ibid.*, at p 5.

<sup>458</sup> Ogbolu, Johantgen, Zhu & Johnson, *Nurse reported patient safety in low-resource settings: a cross-sectional study of MNCH nurses in Nigeria* (2015) 28 *Applied Nursing Research* 341, at 344.



*nursing care as they deem fit”.*<sup>459</sup>

### *Implications for the Law of Negligence*

What emerges from the empirical research is that nurses are overworked in Nigeria, having to take on extra responsibilities on account of the dearth of doctors. As a result, their performance is somewhat substandard. They make errors, endangering patient safety, and their general attitude to patients can be overbearing, which, albeit indirectly, also damages patient welfare.

In addressing the issue of negligence, courts therefore have a difficult task in distilling from the facts the elements that are infrastructural or social – such as the lack of doctors – and the elements that are personally attributable to the individual nurse. This is a good deal more complex than might first appear. If one assumes for a moment that a nurse should not be blamed for the dearth of doctors, the implication may be that the nurse should not be blamed for errors that he or she makes as a result of overwork caused by such lack of doctors. But is it really possible for a court in any particular instance of error by a nurse to trace the causal connection to overwork resulting from the shortage of doctors? Surely such a connection can be established only at the macro level, and not the specific level of the particular instance of the consequences of the macro decision?

Moreover, it would seem unjust to patients to deny them compensation for injury caused by a nurse’s error, even where that error can be traced to overwork resulting from the shortage of doctors. Just as a bus driver involved in an accident on account of having to work too many hours may not escape liability to an injured passenger so also a nurse who has been admittedly careless should not be exempt from liability by reason of the fact that such carelessness is the product of an

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<sup>459</sup> Oyetunde & Ofi, *Nurses’ knowledge of legal aspects of nursing practice in Ibadan, Nigeria* (2012) 3 J of Nursing Education and Practice 75, at 77.

unsatisfactory medical care system at the national level. Principles of vicarious liability would mean that the employer in such circumstances would be obliged to compensate the patient.<sup>460</sup>

### *Caselaw on Nurses' Negligence*

Let us now examine the law on nurses' negligence. It can be explained best by looking to the history of nursing.

Traditionally, nurses' duties were circumscribed in scope.<sup>461</sup> Their role was regarded as that of implementing instructions of doctors rather than exercising independent judgment.<sup>462</sup> The courts over the years, following the advancement in technology and the training of nurses and midwives, became disposed to prescribe a more expansive scope of duty to act with reasonable care than merely that of informing doctors about patients' symptoms and following instructions.<sup>463</sup>

It is a matter of some comparative interest that courts in Africa have been willing to apply to nurses the test for professional negligence that is applicable to doctors.

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<sup>460</sup> As well as being vicariously liable, the hospital itself should also arguably be liable in negligence for tolerating a system of healthcare delivery that involves nurses being overworked. Whereas a court might consider it inappropriate to impose liability on the hospital for the lack of doctors, it would be unlikely to defer to unsafe work patterns tolerated by the hospital, even where these patterns are the indirect consequence of the shortage of doctors.

<sup>461</sup> Oyetunde & Ofi, *Nurses' knowledge of legal aspects of nursing practice in Ibadan, Nigeria* (2013) 3 J of Nursing Education and Practice 75, at 75.

<sup>462</sup> In *Richardson v Doe* (1964) 176 Ohio St. 370, at 373, the Supreme Court of Ohio considered the scope of nurses' duty, Matthias J stated: "A nurse, although obviously skilled and well trained, is not in the same category as a physician who is required to exercise his independent judgment on matters which may mean the difference between life and death. ... Her primary function is to observe and record the symptoms and reactions of patients. A nurse is not permitted to exercise judgment in diagnosing or treating any symptoms which the patient develops. Her duty is to report them to the physician." In *Paul S. Albert Itule v Theresia Andrea & Anor* [1980] Tanzania LR 98, the Tanzania High Court held that the defendant's failure to send the baby to the special ward, though it was a contributory cause for the death of the baby, did not amount to negligence as she acted in accordance with the instruction given to the nurses to send a newly born child to the special ward only if its birth weight was below 2.0kgs, unless there were untoward symptoms calling for admission there and in this case the birth weight of the child was over 2.0kgs and his general condition was good. Mfalila J (at 111) stated: "[B]ut this I have held did not amount to negligence on her part because she was acting on standing instructions based on professional judgment which appears to have worked pretty well until this mishap involving the plaintiff's baby happened".

<sup>463</sup> In *Heidebrecht v The Fraser-Burrard Hospital Society* [1996] 15 BCLR (3d) 189, the British Columbia Supreme Court held that: Generally, expert evidence is required to establish the standard of care expected of a registered nurse of average competence. A. G. Henderson J (at para 121) stated: "Nursing is an independent profession with its own practice, procedures, and standard of competence".

Thus, in *The Administrator, HH The Aga Khan Platinum Jubilee Hospital v Munyambu*,<sup>464</sup> where the plaintiff sued the defendant hospital for negligent nursing care in relation to his right leg which was plastered as a result of motor accident, the Kenyan Court of Appeal adopted the principles stated in *Hunter v Hanley*.<sup>465</sup> Kneller JA, stated:

*“This is related to doctors but, in my respectful view, it is also the right test to apply to the diagnosis and treatment on the part of surgeons, anaesthetists and nurses.”*

The Ghanaian Court of Appeal also equated the skill of a doctor with that of a treating nurse in *Gyan v Ashanti Goldfields Corporation*.<sup>466</sup> The plaintiff, a one-year old son of an employee of the defendant was diagnosed with malaria by the attending nurse, who gave him a chloroquin injection. It turned out that the cause of the fever was not malaria but polio and that the administration of the chloroquin injection had resulted in the paralysis of the patient’s right leg. The plaintiff alleged that, if a proper diagnosis had been made prior to the treatment, it would have been discovered that the plaintiff was suffering from polio or, at least, that polio should have been suspected. Essiem JA, delivering the majority judgment, applied a test of customary practice of doctors in assessing the negligence of the nurse. He stated:

*“I am of the opinion that on the evidence on record the senior nurse, ... who treated the infant plaintiff on his attendance at the hospital casualty ward did what most, if not all, medical men would have done*

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<sup>464</sup> [1985] eKLR.

<sup>465</sup> 1955 SC 200.

<sup>466</sup> [1991] 1 GLR 466.

*in the circumstances.*<sup>467</sup>

The position is the same in South Africa. In *Hoffmann v MEC for Department of Health, Eastern Cape*,<sup>468</sup> the plaintiff claimed that, while under the care of the defendants for delivery she had informed the nurse that she was a diabetic and hypertensive patient who required a caesarean operation, but that the nurses had recorded the direct opposite of what the plaintiff had told them. As a result, the caesarean operation was carried out very late and the plaintiff gave birth to stillborn baby. In finding for the plaintiff, Tshiki J stated:

*“[I]n the case of an expert such as a surgeon or gynaecologist, the test for negligence in regard to the exercise of the expert’s area of activity is the test of the so called reasonable surgeon, reasonable gynaecologist ... and the negligence of an expert is sometimes referred to as professional negligence. This applies equally to professional nurses whose conduct is also judge according to their rank and experience. A nurse who has progressed to the rank of a sister, in certain circumstances, will be judged according to the reasonableness of a nursing sister and not that of a student nurse. The same holds true*

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<sup>467</sup> *Ibid.*, at 474. Cf *Hoffmann v MEC for Department of Health, Eastern Cape* [2011] ZAECPEHC 39, at para 65-66, the South Africa Eastern Cape High Court held the standard of care of nurses on “reasonableness”. The court stated: “The hospital has employed professional nurses and qualified doctors who have to deal with the patients who come to hospital for delivery of babies and other illness. Both nurses and doctors in their own right possess or at least should reasonably be expected to possess proficiency or expertise in regard to their areas of proficiency and/or expertise. Thus in the case of an expert such as a surgeon or gynaecologist, the test for negligence in regard to the exercise of the expert’s area of activity is the test of the so called reasonable surgeon, reasonable gynaecologist *etc* and the negligence of an expert is sometimes referred to as professional negligence. This applies equally to professional nurses whose conduct is also judged according to their rank and expertise. A nurse who has progressed to the rank of a sister, in certain circumstances, will be judged according to the reasonableness of a nursing sister and not that of a student nurse. The same holds true in the case of a general practitioner who should exercise the same degree of skill and care as that of a reasonable medical practitioner and not that of a reasonable specialist. He or she is in fact not a specialist but a medical practitioner.”

<sup>468</sup> [2011] ZAECPEHC 39.

*in the case of a general practitioner who should exercise the same degree of skill and care as that of a reasonable medical practitioner and not that of a reasonable specialist. He or she is in fact not a specialist but a medical practitioner.*<sup>469</sup>

This approach by African courts is similar to that now generally adopted in courts in the United States of America,<sup>470</sup> Canada<sup>471</sup> and Ireland<sup>472</sup>.

#### *Looking to the Future in Nigeria*

What approach to nurses' negligence is best for Nigeria? It might be thought that a conservative solution is preferable, whereby nurses would not be subject to the professional standard. I suggest, however, that imposing a professional standard is the right way forward. Nurses in Nigeria often have important responsibilities requiring intellectual judgment.

The lack of resources means that, of necessity, they may be forced into this role. It should be noted that placing nurses under the professional negligence test actually affords them a wider legal protection as adherence to a customary practice will afford them a defence unless the particular practice had obvious inherent defects.

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<sup>469</sup> *Ibid.*, at para 66.

<sup>470</sup> McClellan, Frank & Hansen-Turton, *Nurse Practitioners In Primary Care* (2010) 82 Temple L Rev 1235, at 1252. For a subtle analysis of possible distinctions between the standard of care of doctors and nurses, see Hansen-Turton & Ware, *Nurse Practitioners in Primary Care* (2010) 82 Temp L Rev 1235, at 1251-1253.

<sup>471</sup> *Skeels (Estate of) v Iwashkiw* [2006] ABQB 335.

<sup>472</sup> *Hamilton v Health Services Executive* [2014] IEHC 393.

## **Chapter Eight**

### **Informed Consent to Medical Treatment**

#### *Introduction*

In this Chapter, I examine the law relating to informed consent in Nigeria. I analyse the extent to which Nigerian courts at present require health service personnel to explain to patients the risks associated with any proposed course of treatment and I consider how best the law might be developed in the future so as to respect the value of autonomy in the distinctive culture of Nigeria which is very difficult from that of New York or London. There is very little case law directly in point: indeed, this is a feature of the law in all African common law states, in contrast to states – most notably South Africa – that follow the Roman Dutch legal tradition. It is necessary, therefore, to take a broader, comparative law perspective.

#### *The African Cultural Context*

Before examining the main features of the law on informed consent to treatment, it may be useful to refer to the sociological aspects of the subject. In contrast to North

America and Western Europe,<sup>473</sup> Nigeria, like many other African states, has a social structure which, if not entirely inimical to the value of autonomous choice underlying the contemporary informed consent doctrine, is certainly not particularly congenial to it. Several social factors converge here.

First, Nigerian society embraces an interpersonal value system which emphasizes the communal and downplays the individual. This system is harmonious with that of other African states and is perhaps most strikingly captured by the concept of *Ubuntu*<sup>474</sup> (humanness), which has shaped the new constitutional jurisprudence of South Africa.<sup>475</sup> Kiwanuka has observed that African humanism:

*“stands in stark contrast to the atomistic view of the Western world, which regards individuals as locked in a constant struggle against society for the redemption of their rights.”*<sup>476</sup>

The African Charter on Human and Peoples’ Rights, with its emphasis on duties as well as rights, together with its recognition of the need for family and social solidarity, reflects this same philosophy.<sup>477</sup> The late Nigerian anthropologist, Victor Uchendu, is quoted as having observed that the kinship principle prevailing in West Africa:

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<sup>473</sup> See generally Michael Jones, *Informed Consent And Other Fairy Stories* (1999) 7 Med Law Rev 103.

<sup>474</sup> Bolden R, “Ubuntu”, In: D Coghlan & M Brydon-Miller eds, *The SAGE Encyclopedia of Action Research* (SAGE Publications Ltd, 2014) at Vol. 21, p 800-802; Mbangu A Muyingi, *African Ethics and the Moral Possibilities of Ubuntu towards Conflict Resolution in the Democratic Republic of Congo (DRC)* (2013) 4 Mediterranean J of Social Sciences 561.

<sup>475</sup> The most prominent judicial analysis of *Ubuntu* is that of *S v Makwanyane & Anor* [1995] ZACC 3, where the South African Constitutional Court unanimously held that the death penalty was inconsistent with the protection of human rights in the Constitution.

<sup>476</sup> Richard N Kiwanuka, *The Meaning of "People" in the African Charter on Human and Peoples’ Rights* (1998) 82 Am J of Int’l L 80, at 82.

<sup>477</sup> Benjamin E Winks, *A Covenant of Compassion: African Humanism and the Rights of Solidarity in the African Charter on Human and Peoples’ Rights* (2011) 11 African Human Rts L J 447.

*“provided the individual with a community whose moral order emphasised shared values, a sense of belonging, security, and social justice. In such social order duties preceded rights. The principle was clear: to enjoy your rights you must do your duty; and duty and right have a reciprocal relationship, and structurally both were balanced.”*<sup>478</sup>

Similarly, and more recently, Vasti Rosado-Tisgie, writing of the social philosophy of the Igbo, states:

*“To exist as an individual means to belong to a community in the Igbo world view of umanna. The Igbo have many proverbs that allude to this world view of solidarity. The Igbo say: Mmaduti maka ibeya (one exists because of the other). Another proverb says: Azubuile (union is greater). These proverbs demonstrate the importance of ... community solidarity for the Igbo. They demonstrate the moral value that one cannot exist, live or thrive without the existence of the other or the community, and they emphasize how the community is more important than the individual.”*<sup>479</sup>

Against this background, the concept of the deracinated individual whose informed consent must be obtained as a condition of respect for individual autonomy seems curiously foreign to Nigerian culture.<sup>480</sup>

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<sup>478</sup> Uchendu, *“Tradition and social order”*, Inaugural Lecture, University of Calabar, 11 January 1990, cited by U Umozurike, *The African Charter on Human and Peoples’ Rights* (1997) p 19.

<sup>479</sup> Vasti Rosado-Tisgie, *Traditional Conflict Resolution Skills: Nigeria Case Study*, “B. A. Thesis, Department of Peace, Justice and Conflict Studies, Goshen College, Indiana”, (May 2014) at p 19-20.

<sup>480</sup> It is, in fact, not clear that North American and Western Europe culture has actually reached the point of embrace of autonomy which the law presumes in its informed consent rules. Cf Charles Foster, *Autonomy in the medico-legal courtroom: a principle fit for purpose?* (2014) 22 Med L Rev 48, at 61-62, states: “The law ... tends to say that respect for autonomy is a non-negotiable axiom, is very reluctant to acknowledge th[at patients place autonomy well down this lists of priorities] ... There is a limited right not to know. That may be what autonomy regards; but autonomy is not what people want or value most here.”



A second challenge to the notion of individualistic informed consent in Nigeria is one deriving from an aspect of Nigerian social organisation that is clearly unpalatable to North American and Western European values: gender inequality. In Africa, as well as there being significant disparities based on such factors as religion, class, education and urban/rural divisions, the culture is far from one of gender equality. Men still tend to make important decisions, relating to the family, including decisions as to the medical welfare to women and children.<sup>481</sup> This can have clearly detrimental, even fatal, for women.

Research<sup>482</sup> carried out at the Federal Medical Centre, Azare, in Bauch State found that the need to obtain the consent of the husbands<sup>483</sup> of patients facing an emergency during pregnancy resulted in delays, which significantly increased the risk of death. While the report of this research is not entirely clear on the matter, it appears that consent was in all cases first sought from the patient and, only if she refused, was the consent of her husband solicited by medical personnel. In such circumstances, it appears that the patient's refusal was premised on her acceptance of the legitimacy of seeking her husband's consent. There is no suggestion in the report of the research that the husband's consent was regarded as overriding the patient's refusal, but the absence of reference to this question leaves some uncertainty.

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<sup>481</sup> See Ezeome & Marshall, *Informed Consent Practices in Nigeria*. (2009) 9 *Developing World Bioethics* 138, at 144.

<sup>482</sup> Bako, Umar, Garba & Khan, *Informed Consent Practices and its Implication for Emergency Obstetrics Care in Azare, North-Eastern Nigeria* (2011) 1 *Ann Med Health Sc Res* 149.

<sup>483</sup> It was not always a matter of obtaining the husband's consent. The study reports (at 155), that: "[u]nfortunately, even the husbands are sometimes not empowered to give consent in the society especially if [they] cannot bear the financial burden of the treatment. In this situation, the consent will be given by the parent, in-laws or other relatives ... These people often do not accompany the patient to the hospital and reside in remote areas. The logistics in reaching out to them often leads to the delay in obtaining consent."

As regards the wider perspective of gender inequality in Nigeria, there are significant restrictions on female inheritance rights<sup>484</sup> and gender roles tend still to be structured in traditional ways.<sup>485</sup>

Religion is an undoubted factor in contributing to gender inequality. Islam is the dominant religion in the Northern part of Nigeria. In eight Northern states, over 80% of women are unable to read, compared with 54% of men.<sup>486</sup>

### *Contemporary Medical Practice in Nigeria Regarding Consent*

It may at this point be helpful to consider the practical realities of Nigerian hospitals in respect of seeking informed consent to treatment. The picture that emerges from the research is one that gives cause for serious concern.<sup>487</sup> Let us look in detail at the main findings of that research.

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<sup>484</sup> Babalola Abegunde, *Gender Inequality: Nigerian and International Perspectives* (2014) 17 British J of Arts & Social Science 165, at 167-168.

<sup>485</sup> Kayode Fayokun, *Gender Justice in Nigeria: Incoherence of Global Treaties and Customary Law* (2015) 12 US-China L Rev 676; Dickson, Aloba & Egbe, *Women, gender equality in Nigeria: a critical analysis of socio-economic and political (gender issues)* (2014) 4 J Researcher in Peace, Gender & Development 15.

<sup>486</sup> Chinwe Julie Abara, *Inequality and Discrimination in Nigeria: Tradition and Religion as negative Factors Affecting Gender*, "A paper presented at National Council for Arts & Culture, Nigeria" (10 October 2012).

<sup>487</sup> See Lawal, Garba, Ogirima, Dahiru, Maitama & Abubakar, *The doctrine of Informed Consent in surgical practice* (2011) 10 Annals of African Med 1; Ezeome & Marshall, *Informed Consent Practices in Nigeria* (2009) 9 Developing World Bioethics 138, at 141-142; Ogundiran & Adebamowo, *Surgeons' opinions and practice of informed consent in Nigeria* (2010) 36 J Med Ethics 741; Ogundiran & Adebamowo, *Surgeon-Patient Information Disclosure Practices in Southwestern Nigeria* (2012) 21 Med Principles & Practice 238; Afolabi, Fadare & Ajiboye, *Informed Consent in Otolaryngologic Surgery: Case Scenario from a Nigerian Specialist Hospital* (2014) Case Reports in Otolaryngology 1; Abiola, Udofia & Abdullahi, *Patient-doctor relationship: The Practice orientation of doctors in Kano* (2014) 17 Nigerian Journal of Clinical Practice 241, at 244-245; Ezeome, Chuke & Ezeome, *Contents and readability of currently used surgical/procedure informed consent forms in Nigerian tertiary health institutions* (2011) 14 Nigerian Journal of Clinical Practice 311; Iyoke, Ezugwu, Lawani & Onyebuchi, *Ethical aspects of obstetric care: expectations and experiences of patients in South East Nigeria* (2013) 5 Int'l J of Women's Health 571; Manafa, Lindegger & Ijsselmuiden, *Informed consent in an antiretroviral trial in Nigeria* (2006) 4 Indian J of Med Ethics 26; Osime, Okojie, Osadolor & Mohammed, *Current Practices and Medico-Legal Aspects of Pre-operative Consent* (2004) 81 East African Med J 331; Taiwo & Kass, *Post-consent assessment of dental subjects' understanding of informed consent in oral health research in Nigeria* (2009) 10 BMC Med Ethics 11; Agu, Obi, Eze & Okenwa, *Attitude towards informed consent practice in a developing country: a community-based assessment of the role of educational status* (2014) 15 BMC Med Ethics 77; Ezeome & Marshall, *Informed Consent Practices in Nigeria* (2009) 9 Developing World Bioethics 138, at 141-142; Bhan, Majd & Adejumo, *Informed consent in International Research: Perspectives from India, Iran and Nigeria* (2006) 3 Med Ethics 36; Bako, Umar, Garba & Khan, *Informed Consent Practices and its Implication for Emergency Obstetrics care in Azare, North-Eastern Nigeria* (2011) 1 Ann Med Health Sci Res 149; Okonta, *Obstetrics and gynaecology residents' knowledge of the informed consent process and its practice in their training institutions* (2015) 18 Nigerian J of Clinical Practice

(i) *Inadequate Consent Forms*

The consent forms used in Nigerian hospitals for surgical interventions have been the subject of criticism. One study, published in 2011, found that the consent forms specifically mentioned the benefits of the procedures in 54% of cases, whereas “risk disclosures were only mentioned in specific terms in 11.4% of the forms.”<sup>488</sup> This study also found that such information as was provided was written at a level of greater linguistic complexity than ought to be adopted in documents for general public consumption, a factor that “becomes more significant when we know that the average adult literacy rate in Nigeria is estimated to be 65.7% ...”<sup>489</sup>

A study of patients undergoing obstetric and gynaecological surgeries at a teaching hospital in Osun State, 55.5% of whom had received tertiary education, revealed that 23.9% had not been really sure of what they were agreeing to when signing the consent form<sup>490</sup>.

(ii) *Hostile Attitude of Surgeons to Obtaining Informed Consent*

A cross-sectional survey<sup>491</sup> of surgeons<sup>492</sup> working in Nigeria, undertaken in 2004-2005 and reported in 2010, found that only 5.9% responded “yes” to the question whether they provided adequate information for their patients to consent or decline

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445; Aniaka Oluchi, *Patient Right and the Socio-Cultural Challenges to Informed Consent in Nigeria* (2013) <http://ssrn.com/abstract=2267336> or <http://dx.doi.org/10.2139/ssrn.2267336>.

<sup>488</sup> Ezeome, Chuke & Ezeome, *Contents and readability of currently used surgical/procedure informed consent forms in Nigerian tertiary health institutions* (2011) 14 *Nigerian J of Clinical Practice* 311, at 313.

<sup>489</sup> *Ibid.*, at 315.

<sup>490</sup> Atanda, Owonikoko & Adeniji, *Pre-operative written consent in Nigeria: How informed are our patients?* (2013) 4 *J of Med & Med Sciences* 307.

<sup>491</sup> Ogundiran & Adebamowo, *Surgeons' opinions and practice of informed consent in Nigeria* (2010) 36 *J of Med Ethics* 741.

<sup>492</sup> More than half of the respondents were surgeons in training. The authors of the survey comment (at p 6 of the electronic version), that, “since the residents are the ‘lieutenants of consultants,’ and they do most of the informed consent, the information in this report can be taken to be a true reflection of the status quo.”

surgery<sup>493</sup>. Asked if they thought that patients had the right to refuse to give consent to proposed surgical treatment, 2.9% responded in the affirmative while 92.2% said they did not know<sup>494</sup>. When asked to choose from a list of responses as to what they would do if their patient declined to provide consent for a proposed procedure, 89.2% said that they were likely to “threaten the patient”.<sup>495</sup>

This is the term used by the researchers themselves in the provision of the list of options to respondents and it is an unfortunate one. A “threat” connotes a very wide range of conduct, from a threat to the physical safety of the patient (which one hopes was not envisaged by any respondent) to the intimation of some mild sanction. At all events, it is alarming that nine out of ten respondents confirmed a response that fall within the characterisation of being a threat.

### (iii) *Failure to Explain Risks to Patient*

A study<sup>496</sup> of the expectations and experiences of obstetric care patients at three medical care centres in Enugu and Abakaliki found that the patients reported strikingly low levels of counselling for caesarean section procedures. 80% reported that there had been no detailed explanation of the short-term maternal risks (such as primary haemorrhage or injury to the bladder)<sup>497</sup>; 90% reported that there had been no detailed explanation of long term maternal risks (such as higher risks for placenta previa and uterine rupture in subsequent pregnancies)<sup>498</sup>; and 100%

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<sup>493</sup> 36 J of Med Ethics 741, at p 3 of the electronic version (2010).

<sup>494</sup> Ogundiran & Adebamowo, *Surgeon's opinion and practice of informed consent in Nigeria* (2010) 36 J of Med Ethics 741. It seems clear that the respondents understood “right” have to connote “legal right”.

<sup>495</sup> *Ibid.*

<sup>496</sup> Iyoke, Ezugwu, Ugwu, Lawani & Onyebuchi, *Ethical aspects of obstetric: expectations and experiences of patients in South East Nigeria* (2013) 5 Int'l J of Women's Health 571.

<sup>497</sup> *Ibid.*, at 576.

<sup>498</sup> *Ibid.*

reported that there had been no explanation of the surgery itself, including its duration and the types of abdominal incision it might involve<sup>499</sup>.

A study<sup>500</sup> of antiretroviral therapy trial carried out in Nigeria on HIV patients revealed that the subjects had a good grasp of the benefits of the study but a poor understanding of the risks involved: “a large percentage did not even know that risks were involved in participating.”<sup>501</sup> The authors discovered that the research team that had carried out the trial had:

*“seemed to avoid discussing potentially controversial or complicated issues. The risks were explicitly explained in the information leaflet, but participants appeared to have little or no understanding of these risks. There could be many reasons for the researchers’ inadequate disclosure of risks, such as cultural sensitivity, exploitation of the participants, and inadequate understanding of what a consent process involves.”*<sup>502</sup>

A study<sup>503</sup> of 133 patients at the University of Benin Teaching Hospital in Nigeria in 2002 revealed that 108 (81.2%) of them said that they had not been informed of the risks associated with the procedures<sup>504</sup>. 52 (39.1%) had not been given an opportunity to ask questions<sup>505</sup>. Those who had been given that opportunity “complained that they were not given enough time to think about the doctor’s

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<sup>499</sup> Iyoke, Ezugwu, Ugwu, Lawani & Onyebuchi, *Ethical aspects of obstetric: expectations and experiences of patients in South East Nigeria* (2013) 5 Int’l J of Women’s Health 571.

<sup>500</sup> Manafa, Lindegger & Ijsselmuiden, *Informed consent in an antiretroviral trial in Nigeria* (2006) 4 Indian J of Med Ethics 26.

<sup>501</sup> *Ibid.*, at 29.

<sup>502</sup> *Ibid.*

<sup>503</sup> Osime, Okojie, Osadolor & Mohammed, *Current Practices and Medico-Legal Aspects of Pre-operative Consent* (2004) 81 East African Med J 331.

<sup>504</sup> *Ibid.*, at 333.

<sup>505</sup> *Ibid.*, at 334.

decision before their consent was obtained.”<sup>506</sup> The study noted that 18 (13.5%) had had difficulty understanding what the doctor was talking about vis-à-vis consent for the operation but had “had to sign all the same so that their operation would not be cancelled.”<sup>507</sup>

#### (iv) *Educational Differentials*

A study<sup>508</sup> of residents of Enugu (not patients, it should be noted) revealed the somewhat surprising finding that more (64.7%) of those with no formal education would “require the doctor to disclose everything about the procedure and be allowed to make a choice” than those with third level education (56.2%)<sup>509</sup>. When asked for reasons for requiring the doctor only to disclose the information that the doctor thinks necessary – a limitation apparently rejected by 64.7% of those with no formal education – 29.2% of those respondents gave the explanation that they might not understand the information, whereas only 2.4% of those with third level education gave that explanation<sup>510</sup>.

#### (v) *Failure to Convey the Nature of Research to Patients*

A study<sup>511</sup> of participants who had just consented to participating in one of three ongoing research projects on oral health at two centres, in Northern and Southern Nigeria, revealed striking findings of ignorance as to the process from which they

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<sup>506</sup> Osime, Okojie, Osadolor & Mohammed, *Current Practices and Medico-Legal Aspects of Pre-operative Consent* (2004) 81 East African Med J 331.

<sup>507</sup> *Ibid.* A study of 150 surgeons working in southwestern Nigeria revealed that 34.3% of them “did not routinely discuss directly overall disease diagnosis, management options and prognosis with patients or their families”: Ogundiran & Adebamowo, *Surgeon-Patient Information Disclosure Practice in Southwestern Nigeria* (2012) 21 Med Principles & Practice 238, at 240.

<sup>508</sup> Agu, Obi, Eze & Okenwa, *Attitude towards informed consent practice in a developing country: a community-based assessment of the role of educational status* (2014) 15 BMC Medical Ethics 77.

<sup>509</sup> *Ibid.*, at p 4 (electronic version).

<sup>510</sup> *Ibid.*, at p 6.

<sup>511</sup> Taiwo & Kass, *Post-consent assessment of dental subjects’ understanding of informed consent in oral research in Nigeria* (2009) 10 BMC Med Ethics 11.

had emerged as recently as less than one hour previously. 46% of the respondents said that they had no idea what research connoted<sup>512</sup>. 92.9% said that they had not known they were in a research study on their dental care<sup>513</sup>. The authors of the study speculate that the compromised understanding which it revealed might have been exacerbated as a result of difficulties in translating key concepts into the particular language of the person undergoing the trial:

*“For example, the word 'research' does not have a corresponding term in the local languages of Northern and Southern Nigeria. The common lingua franca in the southern part where the study was conducted is Yoruba and the closet Yoruba words to research are 'iwadi' or 'ayewo' which actually mean investigation or examination. In the northern part of the country, the commonest language spoken apart from English (for the literate populace) is Hausa. Likewise, the closet word to research in Hausa is 'binchike' which can also be translated to mean investigation.”*<sup>514</sup>

### *Conclusions from the Research on Informed Consent*

What emerges from this substantial volume of research is that most Nigerian patients are not provided with sufficient information to enable them to make a fully informed decision as to their treatment. The culture of many hospitals is hostile to

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<sup>512</sup> Taiwo & Kass, *Post-consent assessment of dental subjects' understanding of informed consent in oral research in Nigeria* (2009) 10 BMC Med Ethics 11, at p 3 (electronic version).

<sup>513</sup> *Ibid.*

<sup>514</sup> *Ibid.*, at 5. See also, in this regard, Bhan, Majd & Adejumo, *Informed Consent in International Research: Perspectives from India, Iran and Nigeria* (2006) 3 Med Ethics 36, at 40.

the notion of obtaining an informed consent. The process is regarded generally as one that involves obtaining signatures without providing full disclosure of risks.<sup>515</sup>

It would be easy to conclude that the entire healthcare system in Nigeria constitutes a corporate tort against the mass of patients who do not provide their informed consent to the treatment to which they are subjected. Matters are, however, somewhat more complex than this. We have seen that many female patients are content to defer to doctors and their husbands. For the less educated patients, disclosure of several risks to treatment implies a confession of incompetence on the part of the doctor, leading to a loss of confidence in his or her abilities. Autonomous decision-making has not the value ascribed to it which one finds in North America or Europe.

In such circumstances, for the law in Nigeria to prescribe a test for informed consent fully in harmony with the principles holding sway in courts in California, London or Dublin, far from improving the position, might actually cause greater difficulties, for patients and doctors alike.

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<sup>515</sup> The limited protection afforded patients in Nigeria in respect of informed consent may have been a factor: encouraging transnational corporations to exploit the position by causing our medical research in circumstances where it would not be provided in the United State of America or Europe. In *Abdullahi v Pfizer* (2009) 562 F. 2d 163, the defendants administered "trovan" test drugs on some selected children who were suffering from meningitis without their informed consent or the consent of their guardians. The test caused the death of eleven children and left many injured with a various degree of disabilities; including, deafness, blindness, paralysis and brain damage. The plaintiff alleged violation of customary international law prohibiting involuntary medical experimentation on human subjects. The Court of Appeals examined whether a customary international law is sufficiently specific and universally accepted for courts to recognize a cause of action to enforce the norm of international law. The Court found the defendants liable on the basis of no reasonable iteration of the prohibition against involuntary medical experimentation. Barrington D. Parker (at para 185) stated:

*"While the prohibition in question applies to the testing of drugs without the consent of human subjects ..., we do not suggest that it would extend to instances of routine or isolated failures by medical practitioners to obtain informed consent, such as those arising from simple negligence. The allegations in the complaints involve anything but a doctor's routine or failure to obtain such consent from his patient."*



I examine this dilemma in greater detail at a later stage in this Chapter. I turn now to analyse the main features of the law on informed consent in common law jurisdictions.

### *Informed Consent in Other Common Law Jurisdictions*

The first question that arises concerns the scope of disclosure that a doctor should be required to make to the patient of risks inherent in proposed treatment.<sup>516</sup> Three main approaches have found support in the traditional common law jurisdictions<sup>517</sup> various jurisdictions at various times.

The first of these approaches regards the provision of such information as essentially a matter of medical judgment and discretion, to be determined by doctors themselves. This approach is in harmony with the *Bolam* test, so far as that test was for many years regarded as affording complete deference to customary medical practice.

The second approach generally defers to the disclosure – or, more particularly, non-disclosure – practices of doctors but reserves to the court the entitlement to hold that the failure to disclose a particular risk was culpable as disclosure had been “obviously necessary” in the circumstances.

The third approach begins with a focus on the patient rather than on medical practice. It emphasises the value of autonomy and requires that doctors disclose all material risks to the patient. What constitutes materiality is a matter of judicial debate. It can relate to risks considered material by the particular patient or by a hypothetical reasonable patient in the circumstances of the patient in question.

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<sup>516</sup> See generally Jose Miola, *On The Materiality of Risk: Paper Tigers And Panaceas* (2009) 17 Med Law Rev 76.

<sup>517</sup> The United Kingdom, Ireland, the United States of America, Canada and Australia.

Whichever of these three approaches is adopted, all of them are subject to the defence of therapeutic privilege.<sup>518</sup> The House of Lords in *Sidaway v Board of Governors of the Bethlem Royal Hospital*,<sup>519</sup> acknowledged that doctors had a "therapeutic privilege" not to warn of material risks where they reasonably believe that communication to the patient of the existence of the risk would be detrimental to the health, including mental health of the patient. Lord Scarman expressed the scope of this privilege in surprisingly broad terms:

*"[T]here is the need that the doctor should have the opportunity of proving that he reasonably believed that disclosure of the risk would be damaging to his patient or contrary to his best interest."*<sup>520</sup>

This is a very broad articulation of the therapeutic privilege. A "best interest" test goes beyond a risk of physical or mental injury and would seem difficult to reconcile with the broad principle of respect for autonomy which formed the basis of Lord Scarman's proposed test for disclosure of material risks to the patient.<sup>521</sup>

Assuming that a doctor has failed to make adequate disclosure of risks on one of the three tests mentioned above and that no question of a therapeutic privilege arises, the next question is the test of causation. If the court is satisfied that the patient would have undergone the treatment even if he or she had been properly informed of the risks, the court must reject the claim on the basis of lack of causal

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<sup>518</sup> See Johnson & Holt, *The legal and ethical implications of therapeutic privilege – is it ever justified to withhold treatment information from a competent patient?* (2006) 1 Clinical Ethics 146.

<sup>519</sup> [1985] 1 All ER 643.

<sup>520</sup> *Ibid.*, at 654.

<sup>521</sup> In *Chester v Afshar* [2005] 1 AC 134, at para 16, the House of Lords affirmed the exception to a legal duty to warn patient. Lord Steyn stated: "[T]here may be wholly exceptional cases where objectively in the best interests of the patient the surgeon may be excused from giving a warning."

connection between the negligent act and the injury<sup>522</sup> (I do not here<sup>523</sup> consider the somewhat more refined question of whether the patient should receive compensation for interference with his or her right to autonomy, which has been compromised even in cases where the patient would have undergone the treatment if properly informed of the risks).

Courts in many common law jurisdictions have been concerned that patients who have not been properly informed of the risks and who suffer serious injuries will tend to convince themselves that, if they had been properly informed, they would not have embarked on the risky treatment. To guard against the danger of such understandable self-deception, some courts have applied a "prudent patient" test to the causal question, asking themselves whether a prudent patient, having been properly informed of the risks, would still have undergone the treatment. It should be noted that this "prudent patient" test is not identical with the "prudent patient" test in respect of disclosure of materiality of risks: it is perfectly possible for a court in a particular case to hold that a doctor was guilty of negligence in failing to disclose a material risk, applying the test of what a prudent patient would regard as material, and then go on to hold that the plaintiff's claim should fail on grounds of lack of causation on the basis that a prudent patient, if he or she had been informed of such material risk, would still have chosen to undergo the treatment. This will be the case in situations where, for example, the plaintiff's health condition is so serious as to make it urgently desirable to undergo treatments with certain risks in order to avoid the certainty of a worse outcome if nothing is done.<sup>524</sup>

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<sup>522</sup> Cf *Canterbury v Spence* (1972) 464 F. 2d 772, where Robinson J stated (at 790): "The patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils."

<sup>523</sup> Cf *Chester v Afshar* [2005] 1 AC 134, at para 24; Erin Sheley, *Rethinking Injury: The Case of Informed Consent* (2015) Brigham Young U L Rev 63.

<sup>524</sup> See Anon, *Informed Consent – A Proposed Standard for Medical Disclosure* (1973) 48 New York Univ. L Rev 548, at 550.

It may be useful at this point to embark on the comparative survey of how courts in the traditional common law jurisdictions have dealt with the subject of informed consent to treatment as this will sharpen our focus on the key issues yet to be confronted by the Nigerian courts.

The United States decision of *Schloendorff v Society of New York Hospital*<sup>525</sup> is generally regarded as the source of the doctrine of informed consent. There, Cardozo J, in a famous *dictum*, stated:

*“Every human being of adult years and sound mind has right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.”*<sup>526</sup>

The doctrine of informed consent came to be developed in subsequent years, requiring a doctor to inform a patient of potential risks associated with a proposed course of treatment.

Canada<sup>527</sup> followed suit. The Supreme Court of Canada in *Hopp v Lepp*,<sup>528</sup> adopted a test of material risk, holding that “it is a duty of disclosure to [patient] that affects the validity of his consent, evidence of medical experts of custom or general

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<sup>525</sup> (1914) 211 NY 125; 105 NE 92.

<sup>526</sup> *Ibid.*, at 93.

<sup>527</sup> See McGivern & Ivolgina, *Legal Liability in Informed Consent Cases: What Are the Rules of the Game?* (2013) 7 McGill J of L & Health 129.

<sup>528</sup> [1980] 2 SCR 192.

practice as to the scope of disclosure cannot be decisive, but at most a factor to be considered”<sup>529</sup>.

It was not until 2015 that English law adopted the same approach, in *Montgomery v Lanarkshire Health Board*.<sup>530</sup> Lord Kerr stated:

*“The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it.”*<sup>531</sup>

Two decades previously, in *Rogers v Whitaker*,<sup>532</sup> the High Court of Australia rejected the *Bolam* test and held that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment. A risk was considered material:

*“[I]f, in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This duty is subject to therapeutic privilege.”*<sup>533</sup>

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<sup>529</sup> *Ibid.*, at 209. See further *Rawlings v Lindsay* (1982) 20 CCTL 301 (BC SC); *Bryan v Hicks* [1995] 10 WWR 145 (BC C of A).

<sup>530</sup> [2015] 2 WLR 768.

<sup>531</sup> *Ibid.*, at para 87.

<sup>532</sup> (1992) 175 CLR 479.

<sup>533</sup> *Rogers v Whitaker* (1992) 175 CLR 479, at 490.

In Ireland, the Supreme Court reached the same conclusions in *Fitzpatrick v White*.<sup>534</sup>

The issue of informed consent does not yet appear to have been addressed by Nigerian courts in any detailed way in civil litigation. The Supreme Court of Nigeria has, however, recognised the principle of patient autonomy in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*.<sup>535</sup> The defendant, a medical practitioner attended a patient who was a Jehovah's Witness. In the course of her treatment, she refused to be transfused with blood on the basis of her religious belief, she died and the defendant was charged before a medical disciplinary tribunal with infamous conduct.

The Supreme Court came down firmly on the side of patient autonomy and held that the medical practitioner had acted appropriately. Ayoola JSC stated:

*“[I]t follows that the choice of an adult patient with a sound mind to refuse informed consent to medical treatment, barring state intervention through judicial process, leaves the practitioner helpless to impose a treatment on the patient. ... To a large extent the practitioner should be the judge of the choice that may be better in the circumstances. The choices become a question of personal attitude rather than one of professional ethics. ... If a competent adult patient exercising his right to reject life-saving treatment on religious grounds thereby chooses a path that may ultimately lead to his death, in the absence of judicial intervention overriding the patient's decision, what meaningful option is the practitioner left with, other, perhaps, than to*

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<sup>534</sup> [2008] 3 IR 551.

<sup>535</sup> (2002) AHRLR 159.

*give the patient comfort? ”<sup>536</sup>*

The wider implications of this decision in the context of informed consent to treatment are not easy to state with confidence.<sup>537</sup> The case can best be regarded as focused on freedom of religion rather than necessarily imposing on doctors a stringent obligation to disclose to patients all material risks attaching to a proposed course of treatment.

In *Okekearu v Tanko*,<sup>538</sup> the defendant amputated the left centre finger of the plaintiff, aged 18 years who was injured in the course of removing zinc from his mother’s residence without taking his consent. The plaintiff alleged that the amputation of his left centre finger was an intentional act for which the defendant was liable in battery. The defendant admitted in evidence that he intentionally trimmed off the plaintiff’s finger. The trial Judge, Kolajo J, held that the defendant was liable for the tort of battery. He stated:

*“The fact that the plaintiff submitted himself for treatment by the defendant did not absolve the defendant of battery. To absolve the defendant he must have told the plaintiff or his auntie that he would amputate the finger of the plaintiff. The defendant himself never said he explained this either to the plaintiff or his auntie. All he said is that he showed her Tanko’s (plaintiff) finger and she asked me to carry on with whatever treatment was necessary. Although I do not believe that the defendant sought and got the consent of his auntie to amputate the plaintiff’s finger, the consent he allegedly got is in law insufficient. It*

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<sup>536</sup> *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2002) AHRLR 159, at para 75.

<sup>537</sup> See Aniaka Oluchi, *Patient Right and the Socio-Cultural Challenges to Informed Consent in Nigeria* (Canadian Institute of Health Research, 2013), <https://dx.doi.org/10.2139/SSRN.2267336.p.29>.

<sup>538</sup> (2002) 15 NWLR (Pt. 791) 657.

*amounts to no consent. ... In effects, since the plaintiff or his auntie did not consent to the amputation of the plaintiff's finger, the defendant is no doubt liable in battery to the plaintiff."*

On appeal, the Court of Appeal also found for the plaintiff, but on the basis of negligence rather than battery. It stated:

*"On the issue of battery, the defendant still maintained that he had the consent of his auntie to act as he did on the plaintiff's finger. There is however no evidence to show that the defendant had fully explained the nature of the treatment he was giving to the plaintiff nor did he explain the ill-effects of such treatment. Failure to do any of those would make him liable in negligence."*

On further appeal to the Supreme Court, the issue for consideration was whether the defendant had the plaintiff's consent or that of his guardian to amputate the finger. The Supreme Court reverted to Kolajo J's approach in imposing liability for battery. It stated:

*"The amputation of the plaintiff's finger was done intentionally and without the consent of the plaintiff or his guardian. This means that the defendant is guilty of battery."*

*Okekearu v Tanko*<sup>539</sup> can best be understood as a case involving failure in the doctor to inform the patient or the patient's family of what the doctor intended to

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<sup>539</sup> (2002) 15 NWLR (Pt. 791) 657.



do to the patient (namely amputate a part of his body) rather than a case of mere failure to disclose the risks inherent in a proposed treatment.

Also in the case of *Abi v Central Bank of Nigeria*,<sup>540</sup> the trial court briefly mentioned the issue of informed consent. The plaintiff had been treated with a drug for his medical condition which caused some risks of causing deafness. Nyako J observed simply:

*“The duty of a doctor includes warning the patient of any possible risk with any treatment. There is no evidence to show that the [doctor] warned or did not warn the plaintiff of any such risk.”*<sup>541</sup>

The plaintiff lost his case for negligence as he had not established any evidence that the drug actually caused his deafness. Thus the question of liability for failure to obtain his informed consent necessarily failed. Nevertheless it is interesting that the trial judge stated the duty of disclosure in such broad terms, which are wider than even the position adopted by Lord Scarman in the *Sidaway’s* case.

There is precious little case law in other African common law jurisdictions on the issue of informed consent. The only case that could be found is that of the High Court of Tanzania in *Theodelina v Alphaxad Nkinga Hospital*.<sup>542</sup> The plaintiff’s daughter fell and hurt her arm while the defendants in negligent treatment arising from hospital organisational failure gave instructions to the plaintiff’s father to take the child home and bring her back if she felt pain, swelling and discolouration as a result of the P.O.P casted on the second day of her visit without disclosing the risks or warning of impending harms consequent upon the cast. The arm of the child was

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<sup>540</sup> 20 March 2007 (Federal High Court, Abuja Judicial Division).

<sup>541</sup> *Abi v Central Bank of Nigeria* (20 March 2007), Federal High Court, Abuja.

<sup>542</sup> [1992] Tanzania LR 235.

amputated eventually as a result of the delay in treatment. The defendant shifted blame on the father who failed to bring back her daughter to hospital on instruction. The High Court of Tanzania in assessing the standard of information disclosure in relation to the resultant injury reached a conclusion that it all dependent on the patient's autonomy to be informed of the risk for him or her in taking a reasonable decision. The court found the defendant liable following the knowledge of the risks upon the patient to make informed decision. Katiti J stated:

*“[W]ithout prejudice to the fact, that the minor did any way report about the pains setting in ... when the gangrenous process was already setting in, and the non-disclosure of the real dangers potential to the harm, suffered by the minor, before being discharged to their village, show that by any stretch of imagination of the same, no reasonable care and skill, founded on the appropriate contemporary standards of professional care, were applied to this patient.”<sup>543</sup>*

In South Africa<sup>544</sup>, and other Southern African states where Roman Dutch law prevails, the approach adopted to addressing informed consent is somewhat at variance with the approaches of common law jurisdictions. Whereas in common law jurisdictions the failure to obtain informed consent to medical treatment is characterised as a breach of a duty of care falling within the scope of the tort of negligence on the part of a doctor, in the South African jurisprudence it constitutes an assault. Thus, the consent by a patient to medical treatment is treated as falling

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<sup>543</sup> *Theodelina v Alphaxad Nkinga Hospital* [1992] Tanzania LR 235, at 244.

<sup>544</sup> See Rhiannon Thomas, *Where To From Castell v De Greef? Lessons from Recent Developments in South Africa and Abroad Regarding Consent to Treatment and the Standard of Disclosure* (2007) 124 S Afr L J 188; Van Oosten, *Castell v De Greef and the doctrine of Informed Consent: Medical Paternalism Ousted in Favour of Patient Autonomy* (1995) 28 De Jure 164; Murray Earle, *'Informed Consent': Is There Room for the Reasonable Patient in South African Law?* (1995) 112 S Afr L J 629; Melodie Slabbert, *Medical Law in South Africa* (Kluwer Law International, 2011), paras 127-128.

under the defence of *volenti non fit injuria* (voluntary assumption of risk). This is a significant conceptual difference from the approach adopted in common law jurisdictions but in practice a very similar test for determining informed consent is applied by the South African courts, which are quite content to cite and rely on key decisions from common law jurisdictions.

In *Castell v De Greef*,<sup>545</sup> the plaintiff underwent a precautionary mastectomy. The operation was successful but it was not pain free until she had another operation by another specialist for the revision of the scars. The plaintiff sued the defendant for failure to warn of the material risks and complications of the operation. A full Bench of the Cape Provincial Division undertook an extensive review of the different approaches adopted by the courts from different jurisdictions (including common law jurisdictions) on the doctrine of informed consent and found support for the Australian decision of *Rogers v Whitaker*.<sup>546</sup>

*“[I]n our law, for a patient’s consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case: (a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or (b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.”*<sup>547</sup>

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<sup>545</sup> 1994 (4) SA 408 (C).

<sup>546</sup> (1992) 175 CLR 479.

<sup>547</sup> *Ibid.*, at 409.

In the instant case, the Court reached a conclusion on the evidence of the plaintiff that the materiality of non-disclosure, would not have affected her choice of operation, if warned. Ackermann J taking consideration of a subjective approach of a particular patient, concluded:

*“There is no convincing evidence that [the plaintiff] would have adopted a different course nor, if she had, that a materially better result would have ensued.”*<sup>548</sup>

On the question of causation, South African courts, like their common law counterparts, take the view that the absence of informed consent will not avail a plaintiff for damages unless it is established by evidence that lack of adequate disclosure was both actual and proximate cause of the damage.

In *Louwrens v Oldwage*,<sup>549</sup> the plaintiff suffered intense pain in his right leg and consulted his GP who examined him and referred him to the defendant, a specialist. The defendant upon examination of the plaintiff performed an angiogram which revealed that arteries in the right upper leg were occluded and diagnosed him with ischemia – iliac bi-femoral bypass (small operation). After the operation, the plaintiff alleged that he still felt pain and consulted another specialist who informed him that he had had disc degeneration which had resulted in a prolapsed disc.

The central issue before the court was whether the plaintiff, when he consulted the defendant suffered from a neuralgic or a vascular problem and whether the plaintiff gave informed consent to the procedure which the defendant performed. The court concluded that the two per cent risk that the claudication would occur was so

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<sup>548</sup> *Castell v De Greef* 1994 (4) SA 408 (C), at 430.

<sup>549</sup> [2005] ZASCA 81.

negligible that it had not been unreasonable for the defendant to warn. Mthiyane JA stated:

*“[T]he likelihood of steal occurring, with the resultant claudication, was so negligible that no duty arose on the defendant to mention it and his omission to do so did not constitute negligence. In any event there is no evidence that the plaintiff’s current claudication is due to ‘steal’ or that, if it is the result of ‘steal’, it is due to the cross over bypass performed on the plaintiff. The evidence was that there are many causes of ‘steal’. Poor heart functioning is one of them. ... For the above reasons it was not in my view shown that there was an absence of informed consent or that the claudication was due to the defendant’s surgical intervention.”<sup>550</sup>*

The constitutional right of a patient to be fully involved in his or her medical treatment was stressed by the South African Supreme Court of Appeal in the case of *Premier of the Province of KwaZulu-Natal v Sonny & Anor.*<sup>551</sup> The plaintiff’s daughter was born with Down’s syndrome. The plaintiff claimed that the defendants had been guilty of professional misconduct in failing to inform her that the foetus she carried might be afflicted with Down’s syndrome; had she been thus informed, she could have terminated the pregnancy. The defendant argued that the plaintiff had been the author of her own misfortune by failing to return to the hospital for a second ultrasound scan. The Court rejected this argument. Navsa JA stated:

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<sup>550</sup> *Louwrens v Oldwage* [2005] ZASCA 81, at para 25.

<sup>551</sup> [2011] ZASCA 6.

*“In our country poverty and a lack of literacy abound. Masses of our people attend public health facilities. Their lack of sophistication and the vulnerability that accompanies poverty are factors that cannot be ignored. They are entitled to be treated in the same way as patients who can afford private medical assistance. That means that they should be fully informed and should be as involved as possible in their own treatment. This does not require a drain on public resources. This case is not about the availability of material resources. It is about a doctor communicating adequately with a patient. What is required is a public health delivery system that recognises the dignity and rights of those who are compelled to use its facilities. It is that basic sensitivity that the Constitution demands.”<sup>552</sup>*

### *Informed Consent: The Way Forward*

The comparative law research establishes that courts in the United States of America, Canada, Australia, Ireland and, now, the United Kingdom all require doctors to disclose material risks of prospective treatment to their patients. The former judicial deference to customary practice of non-disclosure has been abandoned. The question that needs to be addressed in the Nigerian context is whether Nigeria should simply introduce a material disclosure test or instead moderate that test to take account of cultural factors, including the strong reliance placed on medical professional expertise and the fact that husbands still exercise a role in decisions as to the medical treatment of their wives, however unpalatable this gender equality may be to contemporary values in America and Europe. I address these concerns in the final chapter.

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<sup>552</sup> *Premier of the Province of KwaZulu-Natal v Sonny & Anor* [2011] ZASCA 6, at para 33. See also *Isaacs v Pandie* [2012] ZAWCHC 47; *Government of Namibia v LM & Ors* [2014] NASC 19 (Namibia Supreme Court), where sterilisation of these women was held to have been carried out without their informed consent.

## **Chapter Nine**

### **Hospital Institutional Liability**

#### *Introduction*

In this Chapter, I analyse the institutional liability of hospitals in Nigeria. The subject is a challenging one as it involves the invocation by the courts of two key concepts which are hard to distinguish, either in theory or in practice: vicarious liability and the non-delegable duty of care.<sup>553</sup> The latter concept emerges, in practice, with the concept of institutional liability. If a hospital lacks basic resources, or is organised in a chaotic manner, the injured patient is entitled to sue the hospital directly for its negligence. In the Nigerian context, this is of considerable importance as it offers patients a straightforward basis of liability. It does, however, raise the perennial question as to whether a hospital starved of resources by the state health system should be considered negligent for failing to deliver a service that is beyond its means. I address this issue in the final chapter and in the legislative solution that I propose. This solution will enable courts to

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<sup>553</sup> See generally Neville Cox, "Suing Hospitals and Health Boards", Chapter 4 of Ciaran Craven & William Binchy eds, *Medical Negligence Litigation: Emerging Issues* (First Law Ltd, 2008) 83.

impose liability on the governmental ministry or agency culpable of failing to have provided the necessary resources to the hospital.

### *Vicarious Liability: Key Policy Concerns*

Vicarious liability is a long-established aspect of the law of torts in common law jurisdictions. Fleming has observed, rightly, that:

*“[t]he modern doctrine of vicarious liability cannot parade as a deduction from legalistic premises, but should be frankly recognised as having its basis in a combination of policy considerations.”*<sup>554</sup>

These policy considerations range broadly and are not always easy to reconcile with conventional notions of corrective justice. Inevitably, courts are required to adopt a perspective that is receptive to considerations of distributive justice.

Let us begin by examining the traditional concept of vicarious liability. Historically, there were three key notions. The first was that employers were likely to be able to afford to compensate the victims of torts done by their employees, in contrast to the wrongdoing employees themselves who often would have few resources. The second was the encouragement to employers to take care in recruiting and maintaining an effective workforce. The third was that it was fair that employers, who were making a profit out of the enterprise for which their employees worked, should have to pay for injuries caused tortiously by those employees.

Vicarious liability is a species of strict liability and it might, perhaps, have been expected that employers, if they were to be required to pay for their employees' torts, should also have to pay for injuries caused by employees who were not guilty

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<sup>554</sup> John G Fleming, *The Law of Torts* (9<sup>th</sup> ed, LBC Information Services 1998), at 410.



of any tort. That this did not happen has been attributed to the early development of the principles of vicarious liability, at “a stage on the route to the full expression of moral enterprise liability”.<sup>555</sup> Had vicarious liability been developed somewhat later, it might indeed not have restricted employers’ vicarious liability to the tortious injurious conduct of employers and would have required employers to compensate those injured by any employee acting in the course of his or her employment.

Courts have sought to base vicarious liability on the notion that employers *control* their employees, in contrast to their independent contractors. This rationale perhaps may have seemed attractive and plausible in the heavily class-based society of Victorian times, where there was an obvious distinction between “servants” and independent contractors. The “masters” (and even “mistresses”) of servants were in a position of hierarchical superiority which (it was believed) gave them the entitlement to order their servants to do particular acts and to tell them how to do them. Servants were obliged to obey, under sanction of being disciplined or dismissed. Over the past century, there has been some relaxation of the class system in many countries, to the extent that the traditional hierarchical system of command and control has been eased. Moreover, many jobs today involve skills and expertise which clearly reside in the employees and not their employers, who exercise no control over how they do their work.

This social transformation has made it harder for courts today to justify the restriction of employers’ vicarious liability to the torts of their employees: the difference between employees and independent contractors is far harder to draw than formerly.

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<sup>555</sup> Jane Stapleton, *Product Liability* (Cambridge University Press 1994), at 194, cited by Fleming, *op cit*, at 411, fn 12.

A further aspect of social history is also important. In the past, the model of vicarious liability developed by the courts concentrated on *private* employers<sup>556</sup>. The public service was tiny in comparison to today; moreover, the relationship between the Crown and those who worked for it, such as soldiers, civil servants and members of the police force was not characterised as one of the employment. The doctrine of Crown immunity meant that questions of vicarious liability were often moot as that doctrine prevented *any* liability from arising.

It has been noted that, for a brief period in the mid – 19<sup>th</sup> century, "English law dallied openly with a comprehensive doctrine of charitable immunity, destined eventually to play a much longer role in the US"<sup>557</sup>. This is a matter of some particular importance in regard to hospitals as at that time hospitals were largely the products of charitable initiatives, often run by religious, or religiously inspired, persons, who provided a physical infrastructure in which the medical consultants were, in essence, visitors. The idea that these doctors should be regarded as the employees of the hospitals was anathema to the Victorian mind. There was no way in which the hospital proprietors could be considered to control these eminent specialists; *a fortiori*, to require doctors to take orders.

Today the position is quite different. Apart from a general easing of class hierarchies, healthcare is now delivered in a completely different way from Victorian times. It is now perceived as a public right rather than one of charitable private benefaction. The State plays an important role in most countries in the provision of healthcare, even in those countries that have not embraced a full public healthcare ethos. Around the world, there is significant difference of approach, ranging from a completely nationalised healthcare system to a highly privatised

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<sup>556</sup> Fleming, *op cit*, at 417.

<sup>557</sup> Fleming, *op cit*, at 417.

system, but, even in countries with a highly privatised healthcare system, such as the United States of America, there is still a significant public delivery of healthcare for the less advantaged members of society.

A further modern cultural development should also be noted as it is relevant to the judicial approach to vicarious liability. This is the growth of a consumerist philosophy, which attaches importance to the choice and entitlements of those who consume goods or services.<sup>558</sup>

Most obviously, a patient who receives healthcare at a hospital is today regarded as a person with a legitimate entitlement to expect that the services he or she receives will be delivered carefully. If there is a failure to deliver on this expectation, the hospital is increasingly regarded by the courts as being liable to compensate the patient, without too close attention being given to the question whether those who failed were employees or independent contractors.

### *The Modern Development of Vicarious Liability Principles*<sup>559</sup>

Let us look a little more closely at how the courts developed their thinking on the subject.

As has been mentioned, formerly hospitals were immune from vicarious liability as they were essentially infrastructural administrative entities providing the care environment in which doctors could carry out their professional duties rather than practicing medicine themselves. In *Hillyer v Governors of St Bartholomew's Hospital*,<sup>560</sup> the English Court of Appeal held that a hospital was not vicariously

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<sup>558</sup> Cf Orkuma & Ayia, *Ethico-legal aspects of hospital-based blood transfusion practice; implications of professional negligence to medical practitioners: a review* (2014) 3 Int'l J Med Biomed Res 219, at 221-222.

<sup>559</sup> See Desmond Ryan, "'Close Connection' and 'Akin to Employment': Perspectives on 50 Years of Radical Developments in Vicarious Liability" (2016) 56 Irish Jurist (ns) 239.

<sup>560</sup> [1909] 2 KB 820.

liable for the negligence by its medical staff<sup>561</sup>. This decision was reached on a view that a person cannot be an employee unless the institution has control<sup>562</sup> over his or her services. However, over the following century, courts gradually proved receptive to taking the pragmatic step of moving beyond the control test to impose liability on hospitals for both breach of duty of care and vicariously liability for the negligent conduct of their employees, including nurses, and for the acts or omissions of independent contractors.

In *Gold v Essex County Council*,<sup>563</sup> Lord Greene first proposed the duty to impose liability on a hospital for the negligence of a radiographer. He stated that the question in determining the defendant's duty to patients was to ask what obligation he had assumed<sup>564</sup>. The hospital was in breach of its duty to treat the patient and was found vicariously liable for the negligent conduct of the radiographer. In the subsequent case in *Cassidy v Ministry of Health*,<sup>565</sup> the court rejected<sup>566</sup> the control test in *Hillyer*.

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<sup>561</sup> Kennedy LJ stated (at 829): “[T]he hospital authority is legally responsible to the patients for the due performance of their servants within the hospital of their purely ministerial or administrative duties, such as, for example, attendances of nurses in the wards, the summoning of medical aid in cases of emergency, the supply of proper food, and the like ...”

<sup>562</sup> Kennedy LJ stated (at 826): “... no surgeon would undertake the responsibility of operations if his orders and directions were subject to the control of or interference by the governing body.”

<sup>563</sup> [1942] 2 KB 293.

<sup>564</sup> *Ibid.*, at 301-304, “... but in each case the first task is to discover the extent of the obligation assumed by the person whom it is ought to make liable. Once this is discovered, it follows of necessity that the person accused of a breach of the obligation cannot escape liability because he has employed another person, whether a servant or agent, to discharge it on his behalf, and this is equally true whether or not the obligation involves the use of skill. It is also true that, if the obligation is undertaken by a corporation, or a body of trustees or governors, they cannot escape liability for its breach, any more than can an individual, and it is no answer to say that the obligation is one which on the face of it they could never perform themselves. Nor can it make any difference that the obligation is assumed gratuitously by a person, body or corporation which does not act for profit. ... It is clear, therefore, that the powers of the defendants include the power of treating patients, and that they are entitled, and, indeed, bound in a proper case, to recover the just expense of doing so. If they exercise that power, the obligation which they undertake is an obligation to treat, and they are liable if the persons employed by them to perform the obligation on their behalf act without due care.”

<sup>565</sup> [1951] 2 KB 343.

<sup>566</sup> *Ibid.*, at 365, Lord Denning stated: “[T]he hospital authorities accepted the plaintiff as a patient for treatment, and it was their duty to treat him with reasonable care. They selected, employed, and paid all the surgeons and nurses who look after him. He had no say in their selection at all. If those surgeons and nurses did not treat him with proper

An Irish court in the relatively recent decision of *Byrne v Ryan*<sup>567</sup> rejected the control test, taking the view<sup>568</sup> that it is not of universal application and that hospital cases are to a considerable extent *sui generis*<sup>569</sup>. Kelly J, in his judgment holding the hospital vicariously liable, remarked:

*“The plaintiff was referred not to a particular surgeon but to the [defendant’s hospital]. She had no say in the choice of who would carry out her sterilisation. It was done by ... He was part of the ‘organisation’ or permanent staff of the hospital. The performance of the operation was part of a service provided by the hospital to the plaintiff. [Defendant] was the person in the hospital’s organisation via whom that service was provided.”*<sup>570</sup>

### *The Non-delegable Duty of Care*

We must now consider a separate possible basis for imposing liability on hospitals: the non-delegable duty of care. This is a form of strict liability, under which a person becomes liable, beyond the scope of vicarious liability, for the torts of independent contractors.

It has long been accepted that those who engage in ultra-hazardous activities should have to compensate victims of the torts of independent contractors.<sup>571</sup> More problematic, and more recent, is the notion that certain relationships should involve the imposition of liability on one party, in respect of a duty owed to the other,

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care and skill, then the hospital authorities must answer for it, for it means that they themselves did not perform their duty to him.”

<sup>567</sup> [2009] 4 IR 542.

<sup>568</sup> See McMahon & Binchy, *Law of Torts* (4<sup>th</sup> ed, Bloomsbury Professional, 2013), at para 43.31.

<sup>569</sup> of its own kind, unique.

<sup>570</sup> *Byrne v Ryan* [2009] 4 IR 542, at 573.

<sup>571</sup> *Honeywell and Stein Ltd v Larkin Brothers (London’s Commercial Photographers Ltd) Ltd* [1934] 1 KB 191.

where some third party is negligent in a manner that impacts on the discharge of that duty. Thus an employer owes a non-delegable duty of care to employees such that, if an independent contractor's negligence in respect of that duty causes harm to an employee, the employer will be liable, even where the employer has not personally been in any way careless.

There is, of course, something fictional about this doctrine. To speak of a "non-delegable" duty is misleading. The truth is that the employer in such circumstances may have in fact fully discharged the duty of care to the employee. The third party, the independent contractor, has breached a *separate* duty of care, owed exclusively by the third party, to the employee. To impose liability on the employer because the employer's duty of care to the employee is "non-delegable" means that the employer is required to pay for the tort of another in circumstances where the traditional rationales for vicarious liability do not justify taking such a step. It can best be understood as a rule of strict liability, extending the principle of vicarious liability beyond its traditional rationales to a new field.<sup>572</sup>

The non-delegable duty of care has been applied in the context of hospitals. In *Cassidy v Ministry of Health*,<sup>573</sup> the Court of Appeal considered the primary duty which a hospital authority owes to its patients generally. Denning LJ stated:

*"Who employs the doctor or surgeon – is it the patient or the hospital authorities? If the patient himself selects and employs the doctor or surgeon, ... the hospital authorities are of course not liable for his negligence, because he is not employed by them. But where the doctor*

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<sup>572</sup> Fleming, *The Law of Torts* (9<sup>th</sup> ed, LBC Information Services 1998), at 434, remarks: "This disguised form of vicarious liability is imposed wherever the defendant is said to be under a 'non-delegable' duty, in the sense that he cannot acquit himself by exercising reasonable care in entrusting the work to a reputable contractor but must actually assure that it is done – and done carefully." See also Christian Witting, *Breach of the Non-Delegable Duty: Defending Limited Strict Liability in Tort* (2006) 29(3) University of New South Wales Law Journal 33.

<sup>573</sup> [1951] 2 KB 343.

*or surgeon, be he a consultant or not, is employed and paid, not by the patient but by the hospital authorities, I am of opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service or a contract for service. That is a fine distinction which is sometimes of importance; but not in cases ..., where the hospital authorities are themselves under a duty to use care in treating the patient. I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for service.*"<sup>574</sup>

This view was repeated in *Roe v Ministry of Health*.<sup>575</sup> The UK Supreme Court in its decision in *Woodland v Essex County Council*<sup>576</sup> affirmed the underlying principle identified by Lord Greene in *Gold's* case and Denning LJ in *Cassidy's* case, identifying specific circumstances under which a non-delegable duty arises. In a key passage, Lord Sumption stated:

*"(1) The claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury. Other examples are likely to be prisoners and residents in care homes.*

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<sup>574</sup> *Cassidy v Ministry of Health* [1951] 2 KB 343, at 362-363.

<sup>575</sup> [1954] 2 QB 66.

<sup>576</sup> [2014] AC 537. For critical analysis, see Jonathan Morgan, *Liability for Independent Contractors in Contract and Tort: Duties to Ensure That Care is Taken* (2015) 74 Cambridge L J 109; Tulley, *Reflections of Woodland v Essex County Council: A Step Too Far for No-fault Liability?* (2016) Birmingham Student L Rev 47.

*(2) There is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, (i) which places the claimant in the actual custody, charge or care of the defendant, and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren.*

*(3) The claimant has no control over how the defendant chooses to perform those obligations, ie, whether personally or through employees or through third parties.*

*(4) The defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant; and the third party is exercising, for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it.*

*(5) The third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.*<sup>577</sup>

It is clear from this set of considerations that hospitals should fall under a non-delegable duty of care to patients unless the circumstances are such as to make it

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<sup>577</sup> *Woodland v Essex County Council* [2014] AC 537, at para 23.



clear to a patient that the hospital has not assumed a positive duty of protection.<sup>578</sup> In cases where a patient privately contracts with a doctor for the provision of healthcare, it may well still be the position that no non-delegable duty of care will be imposed on the hospital for the care provided by the doctor. It will have been clear to the patient that the hospital is, in essence, providing merely the infrastructural support for the delivery by the doctor of the care that he or she has contractually undertaken to the patient.<sup>579</sup> Some cases will be obvious; other cases may be somewhat more ambiguous, as where the hospital provides some significant elements of professional care in addition to the treatment provided by the doctor with whom the patient has privately contracted.

### *The Position in Africa*

Let us now consider the position in Africa. The picture that emerges is that the courts are disposed to apply broad principles of vicarious liability, even extending to imposing a non-delegable duty of care on hospitals. There is, however, some evidence that the judges who take this step are not fully conscious of the difference in rationale as between traditional vicarious liability and the non-delegable duty of care.

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<sup>578</sup> In *GB v Home Office* [2015] EWHC (QB), the issue in this case concerned whether the defendant owed a non-delegable duty of care to the plaintiff so as to render it liable to the plaintiff in respect of any negligence acts or omissions on the part of those providing medical care at Yarl's Wood IRC. Coulson J (at paras 42-43) applying the *Woodland* approach to hospital cases, held:

*"The out-sourcing should be irrelevant in law. Rather, it should not be for [the plaintiff] to have to try and work out which private contractor or individual doctor might be liable for which failure, and then litigate on the basis of that assessment. She was detained by the defendant; she was in the defendant's control; she was entitled to look to the defendant for proper protection. If she did not receive it, the defendant was in breach of its duty. Accordingly, for all these reasons, I conclude that the imposition of a non-delegable duty in this case is fair, just and reasonable. It is also worth undertaking something of a reality check at this point. The defendant decided to detain [the plaintiff], and consequently had clear responsibilities for her treatment as a detainee as a result. It would not be just, fair or reasonable to conclude that those responsibilities disappeared simply because of an outsourcing decision."*

<sup>579</sup> *Reilly v Moir & Ors* [2009] IEHC 164.

In the Nigerian context, the Court of Appeal, Abuja Division in *Abi v Central Bank of Nigeria*<sup>580</sup> declined to hold a patient's employer vicariously liable for the allegedly negligent act of employees of a clinic, which is referred to in Nwodo JCA's judgment as a "retainer hospital" for the Bank's staff. The employer paid for the patient's medical treatment but this did not make it vicariously liable.

In *Igbokwe v University College Hospital Board of Management*,<sup>581</sup> the High Court of Nigeria imposed vicarious liability on a hospital for the negligence of the hospital staff in failing to monitor the condition of a woman who had recently given birth and was suffering from a suspected condition of *post partum* psychosis. The woman died when she fell from the fourth floor of the hospital. A doctor had instructed a staff nurse to "keep an eye" on the deceased.

Irwin J considered it to be "well settled that a hospital authority is responsible for the acts or omissions of the whole of its staff whether they are surgeons, physicians, nurses or other employees ..."<sup>582</sup> In the instant case, both the doctors and nurses whose conduct had been impugned were clearly employees of the hospital so it would seem unwise to interpret Irwin J's remarks, even though they were expressed without qualification, as extending vicarious liability to independent contractors.

In Kenya, there was a clear endorsement of the principles of imposing liability based on a hospital's non-delegable duty of care in *Herman Nyangala Tsuma v Kenya Hospital Association & Ors.*<sup>583</sup> The plaintiff was admitted into the first defendant hospital and was attended by the second defendant, a *locum*, who diagnosed pneumonia and referred the plaintiff to the third defendant who was the

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<sup>580</sup> [2012] 3 NWLR 1. See also *Justina Alfred v The Minister, Federal Capital Territory, Abuja* (24 January 2011) HC; *Unilorin Teaching Hospital v Theresa Akilo* [2000] 22 WRN 117.

<sup>581</sup> [1961] WNLR 173 (HC, Nigeria).

<sup>582</sup> *Ibid.*, at 175 (HC, Nigeria).

<sup>583</sup> [2012] eKLR.

consultant on duty that day, since the plaintiff's condition required immediate attention. The plaintiff suffered injury as a result of the negligence of the second and third defendants. Odunga J had no hesitation in finding the hospital vicariously liable for the acts of the second defendant, stating:

*“That he was a locum or was in temporary employment is neither here nor there. He was an employee of the first defendant and was carrying out his duties pursuant to the instructions of the first defendant. He, for example had no admission rights and was reporting to the first defendant. I therefore have no difficulty in finding that the first defendant is vicariously liable for the acts and omission of the second defendant.”*<sup>584</sup>

With respect to the third defendant, the position was more complicated but Odunga J concluded that the hospital should be vicariously liable for his conduct as well:

*“[T]his was a consultant in private practice and was only on call. However, when the plaintiff went to the first defendant hospital, his main aim was to get treated. How the first defendant went about treating him was none of his business as long as he was treated. He did not choose who was to treat him. The position that was taken by Denning LJ in *Cassidy v Ministry of Health*,<sup>585</sup> was that the liability of doctors on the permanent staff depende[d] on this: Who employs the doctor or surgeon – is it the patient or the hospital authorities? If the patient himself selected and employed the doctor or the surgeon, the*

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<sup>584</sup> *Ibid.*, at para 50.

<sup>585</sup> [1951] 2 KB 342, at 359.

*hospital authorities are not liable for his negligence, because he is not employed by them. Accordingly, in the present matter the first defendant would not be liable for [the plaintiff's general practitioner]'s actions. But where the doctor or surgeon, be he a consultant or not, was employed and paid, not by the patient but by the hospital authorities, the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he is employed is a contract of service or a contract for services. That distinction, important as it is, does not apply in cases where the hospital authorities are themselves under a duty to use care in treating the patient. It is clear law and good sense that where a person is himself under a duty of care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation of it be to a servant under a contract of service or to an independent contractor under a contract of services. Therefore (1) if a person is admitted as a patient to a hospital and suffers injuries through the negligence of some member of the staff it is unnecessary for him to pick upon any particular employee; and (2) The law applies the principle of respondent superior in the case of a hospital just as it does in the case of master and servant in any other sphere of activity, professional, industrial or otherwise and it matters not that the servant does work of a skilful character for which he is specially qualified. The hospital is responsible for all those in whose charge the patient was.*<sup>586</sup>

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<sup>586</sup> *Herman Nyangala Tsuma v Kenya Hospital Association & Ors* [2012] eKLR, at para 51. Contrast with the Nigerian case of *Lagos University Teaching Hospital v Yemi Lawal* [1982] 3 FNLR 184. See also *Aura v Moi Teaching & Referral Hospital* [2012] eKLR.

It seems clear that in this passage Odunga J is endorsing the non-delegable duty principle.

In the Kenyan High Court decision of *M (A Minor) v Amulega & Anor*,<sup>587</sup> the first defendant attended the plaintiff for a tooth extraction. The extraction was negligently carried out. The tooth fell into the plaintiff's mouth during the process and it was inhaled, this causing chest and breathing problems for the plaintiff. The second defendant argued that, even if the doctor was negligent, it could not itself be held responsible or vicariously liable for his negligence. Mulwa J responded as follows:

*“[T]here has been an acceptance from the courts that hospital authorities are in fact liable for breach of duty by its members of staff of a duty owed to the patient. They cannot escape responsibility because, as it were, they themselves were not conducting the operation but rather it was a doctor, with special knowledge and skill who did it and they had no control over his mode of discharging his duties. The argument therefore put forward by the second defendant cannot stand in the face of developments, which have made hospital authorities liable for the negligence of their staff.”*<sup>588</sup>

This analysis is conventional in not requiring proof of control by the employer over the employee's acts. Yet, where Mulwa J referred to the "members of staff" of the hospital, he did not restrict the term "staff" to employees. Mulwa J went on to observe:

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<sup>587</sup> [2001] KLR 420.

<sup>588</sup> *M (A Minor) v Amulega & Anor* [2001] KLR 420.

*“The only reasonable inference that can be drawn in the circumstances of this case is that the first defendant, a practicing medical practitioner, having received and taken under his care patients like the plaintiff who attended the second defendant’s hospital, which among other duties offers medical and dental care services, was a servant or employee of the second defendant. That being the case, it would mean therefore that any negligence in the performance of the first defendant’s duties will make the second defendant vicariously liable. Thus the contention by the second defendant that there was no servitude and or agency with the first defendant is unmeritorious.”*<sup>589</sup>

These remarks appear to extend the liability of the hospital to cover the torts of *all* doctors attending patients in the hospital on the basis of an “inference” that looks very like a disguised *a priori* principle that the hospital should be liable for the torts of all who provide health services within it, regardless of their precise contractual relationship with the hospital. Such a conclusion would follow from the reasoning of the authorities cited with approval by Mulwa J in his judgment.

In the South African case of *Carrim v Premier of the Gauteng Province*,<sup>590</sup> the Gauteng High Court had to consider the boundaries between private and public healthcare. A specialist who first encountered a patient in the context of the provision of private healthcare recommended that the patient be operated upon at a hospital where the specialist worked. The specialist carried out the operation negligently. The hospital unsuccessfully sought to avoid vicarious liability on the

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<sup>589</sup> *Ibid.*, at 425. See also *Alphaxad v Nkinga Hospital* [1992] Tanzania LR 235 (HC, Katiti J).

<sup>590</sup> [2008] ZAGPHC 454.

basis that the specialist's motivation had been to make a secret private profit from his referral of the patient to the hospital. Meyer J, imposing liability on the hospital, stated:

*“In recommending and performing the retroperitoneal surgery, the [specialist]’s subjective intention was not self-directed. He intended to serve the interests of the plaintiff alone. The objective nature of the [specialist]’s actions requires vicarious liability to follow. He acted within the normal course and scope of his employment and duties as defined in his contract of employment with the [hospital] in the treatment that he had given to the plaintiff and in performing the retroperitoneal surgery on the plaintiff. The Chris Hani Baragwanath Hospital serves approximately 6 or 7 million people and is the only hospital in Soweto. The policy of the Chris Hani Baragwanath Hospital is that nobody, not even illegal immigrants, may be refused admission. Ss. 27(1)(a) and 27(3) of the Constitution of the Republic of South Africa, 1996, provide that everyone has the right to health care services and no one may be refused emergency medical treatment. The medical condition of the plaintiff was considered to require immediate treatment and therefore preference was given to him in his admission and in the treatment given to him.”<sup>591</sup>*

This emphasis on the constitutional obligation of hospitals to provide emergency healthcare raises an interesting issue. The patient's expectations in this case were that he would be treated by the specialist in question. He was not simply a patient seeking to avail himself of his constitutional entitlement (of which, perhaps, he was

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<sup>591</sup> *Carrim v Premier of the Guateng Province* [2008] ZAGPHC 454, at para 107.

completely unaware). His focus was on ensuring that the specialist in question treated him. If a hospital's constitutional obligation to provide emergency healthcare is to carry with it the inevitable imposition of vicarious liability, this could result in extensive vicarious liability even in cases where there is a proven significant private relationship between the patient and the doctor working in the hospital. The case thus brings to the forefront the anomalies that can arise with a hybrid healthcare system.

#### *Implication for Future Policy in Nigeria*

It is respectfully submitted that Nigeria would benefit from a clear endorsement of a hospital's non-delegable duty of care. Such an approach, which finds support today in Irish and English law, seems particularly well suited to conditions in Nigeria, where patients cannot be expected to have any particular knowledge of the employment status of each health service provider who cares for the patient. Accordingly, in the concluding chapter of this thesis, the draft legislation on medical negligence claims against healthcare providers includes a provision prescribing a non-delegable duty of care.

With regard to the possibility in Nigeria of suing a hospital for institutional liability for lack of basic resources, resulting in the injury or death of a patient, the legislation which I propose at the conclusion of this thesis enables a court to award damages against a culpable governmental ministry or agency that has failed to provide the basic resources to the hospital.



## **Chapter Ten**

### **Product Liability**

#### *Introduction*

In this Chapter, I examine the scope of product liability claims in the protection of patients receiving medical care in Nigeria. As is the position in regard to medical negligence, neither the courts nor the legislatures in Nigeria have been in the forefront of reform in relation to product liability.<sup>592</sup> It will be necessary, therefore, to adopt a broad comparative analysis in order to distil what appears to be the best way forward for Nigerian law.

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<sup>592</sup> See generally, Adu & Adegoke, "Nigeria – Product Liability 2015", Chapter 25 of Ian Dodds-Smith & Michael Spencer QC eds, *The International Comparative Legal Guide to: Product Liability 2015* (13<sup>th</sup> ed, Global Legal Group) 183; Afe Babalola, "Nigeria", Chapter 14 of Chilton Davis Varner & Bradley W Pratt eds, *The Product Regulation And Liability Review* (Law Business Research Ltd, 2014) 152; Osaro Osemwegie, *Product Liability law in Nigeria: Protection Under Public Law* [www.osaroosewegieandco.com/publications/BARR.%20SARO%20...](http://www.osaroosewegieandco.com/publications/BARR.%20SARO%20...); Ikoni, *Causation and Scientific Evidence in Product Liability: An Exploration of Contemporary Trends in Canada and Some Lessons for Nigeria* (2007-2010) 3 Nigerian Current L Rev 87; Oluwakemi Adekile, *Compensating Victims of Personal Injury in Tort: The Nigerian Experience So Far* (2013) 9 Acta U. Danubius Jur. 144, at 151-154; Bello, Suleiman & Danjuma, *Perspectives on Consumerism and Consumer Protection Act in Nigeria* (2012) 4 European Journal of Business and Management 72; Felicia N. Monye, *Product liability in Nigeria: Okwejinor v Gbakeji & Ors* (2009) 35 Commonwealth Law Bulletin 649; Bakwaph Kanyip, *Consumer Protection in Nigeria – Law, Theory and Policy* (Rekon Books Ltd, 2005).

First, it may be useful to make some preliminary points about the potential utility of strict liability in Nigeria in the context of products used in the delivery of medical care. Of course the primary advantage of strict liability over negligence, from the standpoint of the patient, is that a strict liability regime does not require proof that the defendant was actually careless. Proof that the product was defective, will suffice.

As against this, one should have regard to the limits of the advantages offered by a strict product liability regime. In practice, it represents no great improvement over the operation of the law of negligence, backed by a generous application of the *res ipsa loquitur* principle. It is a striking feature of the law in Britain and Ireland that the adoption of a strict liability regime under the EEC Product Liability Directive of 1985 has resulted in only a trickle of cases. Indeed, in Ireland there has been *no* reported case in which the Directive played a decisive role.

Moreover, strict liability is generally directed towards manufacturers or (more rarely) retailers of products. In the context of medical care, this does not give the patient much of an advantage. It is rare for medicinal products to be designed or manufactured in such a way that they are defective<sup>593</sup>. A further practical obstacle

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<sup>593</sup> Of course, where fake products, resembling those of genuine, reputable manufacturers, are placed on the market, the injured consumer will have a right of action, in theory at least, against the fraudster. In Nigeria, there is a serious problem in this regard. See Oni-Ojo & Iyiola, *Legal implications of manufacturers' negligence and its effects on consumers: A study in South West Nigeria* (2014) 1 Global Scholars Journal of Marketing 1, at 3, state, "Nigeria[n] consumers have been exposed to myriad of problem including problem of safety and quality of product and services. Reports of fake and substandard products gaining ground in Nigeria market is no longer news as these substandard goods are brought in from outside Nigeria and local operators are rentless ... with thousands of porous and unmanned routes and ineffective restrictions. The criminal enterprise most times involves wide-scale conspiracy and corruption. The seriousness of the situation is underscored by the level of high value or fast selling goods targeted: food and beverages, drugs and other pharmaceutical products, electrical items and electronics, vehicle spare parts, batteries, and almost every facet of the economic lives and the quantum of these goods available on the shelves." See also Consumers International & Open Society Initiative for West Africa, *Research Report on the State of Consumer Protection in Nigeria: A Review of Consumer Protection in the Telecommunications Sector in Nigeria* (2014) 1, at 145-146 (detailing an instance where a patent medicine store was shown to be dispensing drugs after their expiration date). A Study carried out by the Federal Ministry of Health, Nigeria (in collaboration with World Health Organisation), *Baseline Assessment of the Nigerian Pharmaceutical Sector* (2002) 1, found that 13 out of 34 public health facilities had poor storage facilities and that most drug stores in public health facilities had "moderately adequate" storage facilities. 7% of the basket of key drugs on health facility shelves were expired. Alarming, the Study Reports (at 25-26), states "[i]t was also observed that there were large quantities of expired drugs in the stores,

is that attempting to prove defectiveness against what often is a multinational enterprise, with sophisticated legal expertise, is beyond the resources of almost any patient, in Nigeria or elsewhere. The Nigerian legal system is not yet designed to facilitate class actions,<sup>594</sup> which might be the way to narrow the disparity of power between plaintiffs and defendants.

In any event, the most common complaint that a patient may have is not that the product was defective but rather that the medical personnel who cared for the patient *misused* a product, or failed to inform and guide the patient in respect of risks relating to the product.<sup>595</sup> Misuse can come in many ways: for example, by selecting a drug that was not appropriate for the patient, by using two drugs in a lethal combination, or by incompetently using basic medical equipment, such as needles. Failure to inform the patient of risks relating to the product can consist of a simple failure to explain the possible side effects of a particular drug, failure to advise the patient to seek further medical advice if he or she develops certain symptoms while using the drug or other product or failure to warn of the dangers of

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indicating either poor drug management or inadequate drug disposal procedures. However, no expired drugs were found on the shelves in the private sector.” The National Agency for Food, Drug Administration and Control (NAFDAC) has been active in this regard: See Chuks Collins, “NAFDAC destroys N500m fake, expired drugs in Awka”, *The Guardian* (Nigeria) 23 February 2013; Ruby Leo, “Nigeria: NAFDAC destroys N135m expired drugs”, *Daily Trust* (Nigeria) 6 February 2013; Beki Abdulfatai, “NAFDAC reaffirms determination to eliminate influx of expired drugs”, *News Agency of Nigeria* (3 May 2015).

<sup>594</sup> See the Nigerian Institute of Advanced Legal Studies, *Communique on the Roundtable on Class Action Litigation in Nigeria* (12 March 2013) [www.nials-nigeria.org/round\\_tables/Communique%20on%20the%20Ro...](http://www.nials-nigeria.org/round_tables/Communique%20on%20the%20Ro...); Oghogho Egusa, *Assessing the Efficacy of Class Action Regimes in Nigeria* <https://greymile.wordpress.com/.../assessing-the-efficacy-of-class-action-regimes-in-nigeria>; Pagaebi Beregba, “Class Action Lawsuits: Protecting the Rights of an Aggrieved Group”, *The Lawyers Chronicle: The Magazine for the African Lawyer* <http://thelawyerschronicle.com/class-action-lawsuits-protecting-the-rights-of-an-aggrieved-group/>.

<sup>595</sup> In *Theodelina Alphaxad v Nkinga Hospital* [1992] Tanzania LR 235, the plaintiff’s daughter who was a minor, aged 6 fell and hurt her arm. The child was not treated on the first day she attended the defendant’s hospital for the facts that it was a X-ray day and the patient in question had eaten before coming to the hospital. As a result, the plaintiff was asked to bring her child back the second day which she complied. The child was anaesthetized and a P.O.P was casted against the affected area. After a few days, the child suffered serious pain arising from the complications of the procedure which led to the removal of the P. O. P having damaged her arm, resulting in its eventual amputation. The High Court of Kenya held that the defendant ought to have foreseen the dangers arising from the procedure and keep the patient in the hospital than sending her home to come back if complications arose. Katiti J (at 243) stated: “In my humble view, failure to take adequate precautions, or act promptly, when the signs of trouble appeared, and to let the patient to go hence, without thorough observations and to leave her unattended ... when she reported, is indefensible, and hardly can it be said, that reasonable standard of care, and skill were applied.”

departing from the prescribed dosage. If a claim in respect of such conduct is to succeed, the plaintiff will generally have to invoke the principles of the law of negligence, and product liability will not be of great relevance.

A second preliminary point may be made. Product liability, in the sense of a strict liability regime, will yield positive outcomes for victims only in a society with a well-developed consumerist culture. Nigeria is emphatically not such a society.<sup>596</sup>

Several factors converge here: lack of awareness by consumers of their legal entitlements<sup>597</sup>, lack of faith in the judicial system<sup>598</sup>, the high cost of litigation<sup>599</sup> and a conservative judiciary.

It is indeed unfortunate that there is such a weak consumerist philosophy in Nigeria because there are many aspects of the healthcare system that are highly dangerous and are crying out for scrutiny by the courts. For example, in Nigeria, as in many developing countries, a severe manpower shortage has led to people with no training in pharmacy being employed in the procurement, storage and distribution of drugs.<sup>600</sup>

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<sup>596</sup> Onyekachi A. Otisi, *Products Liability In Nigeria: The Tort Aspect* (1991) 2 Justice: A Journal of Contemporary Legal Problems 63, at 75, in examining the application of strict liability for defective products in Nigeria, concludes, "Products liability is relatively a new area in Nigeria and it has developed at a very slow pace. Its potential for further rapid growth is hampered by the attitude of the consumers. The average Nigerian consumer is not likely either to take legal action against a manufacturer for injury caused by a defective product or even to make a formal complaint to the manufacturer. Although the society is not a particularly litigious one, it is probable that the major reason for this apathy is that the majority of the people are uninformed and are unaware of the fact that they have a right of action against the manufacturer in the circumstances ... If product liability is not going to develop with litigation, it is obvious that effective legislation is the only answer and the relevant statutes should be given wide publicity."

See also Oluwakemi Adekile, *Compensating Victims of Personal Injury in Tort: The Nigerian Experience So Far* (2013) Acta U. Danubius Jur. 144, at 151-154.

<sup>597</sup> Cf Consumers International & Open Society Initiative for West Africa, *Research Report on the State of Consumer Protection In Nigeria* (January 2014) 1, at 139, states: "Many consumers in Nigeria have little knowledge about existing laws that protect their rights as consumers of products and services. This low awareness is not class, education, gender or location sensitive."

<sup>598</sup> *Ibid.*, at 143.

<sup>599</sup> *Ibid.*, at 144. Victor Essien, *Consumer Protection in Nigeria: The case for Reform* (1984) 16 NYUJ of Int'l L & Pol 515, at 527.

<sup>600</sup> Cf Adikwu U, *Sales practice of patent medicine sellers in Nigeria* (1996) 11(2) Health Policy & Planning 202, at 203, remarks, "All the patent medicine dealers claimed that they were aware that certain drugs should be sold only on prescription. However, only 13% believed that the law is being obeyed. It was also observed that 68.5% of the

Resource constraints and lack of trained personnel also undermine the safety of patients in the area of blood transfusions.<sup>601</sup> The Nigerian National Blood Transfusion Service (NBTS), a body with the mandate to secure a safe blood product, has yet to be established by legislation.<sup>602</sup> Patients generally have to depend on receiving transfusions of blood from other family members or even commercial donors.<sup>603</sup> There are huge risks in this process. Obtaining blood from a family member may give the patient some opportunity to be confident that the blood is not contaminated or affected by HIV, for example, but the system is far from foolproof. Obtaining blood from commercial donors – “touts” who offer their services to those desperately in need of blood – is clearly highly dangerous. The

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patent medicine dealers involved in the study stored food products and cosmetics together with the drugs. Quality control was completely absent in all the stores studied.”

<sup>601</sup> Cf Orkuma & Ayia, *Ethico-legal aspects of hospital-based blood transfusion practice; implication of professional negligence to medical practitioners: a review* (2014) 3 International Journal of Medicine and Biomedical Research 219, at 220, state, “[H]ospital-based blood transfusion is the prevailing practice wherein the sourcing, storage, processing and clinical use of blood and blood products resides in the confines of hospitals most of whom have financial and manpower constraints. In keeping with the advances in knowledge, technology and medical skills, medical law too as evolved and has seen the development as well as the refinement of important medico-legal concepts.” The authors go on to state (at 220): “Unlike in many countries in Africa like South Africa, Burundi, Malawi, central Africa Republic and Botswana where safe blood is efficiently collected and distributed centrally through their country’s National Blood Transfusion Services (NBTS), many resources constrained economies like Nigeria are yet to effectively run nationally coordinated services to meet the blood needs of their populace.”

<sup>602</sup> Erhabor, Isaac, Abdulrahman, Ndakotsu, Ikhuenbor, Aghedo, Ibrahim & Ibrahim, *Female Gender Participation in the Blood Donation Process in Resource Poor Settings: Case study of Sokoto in North Western Nigeria* (2013) 5 J Blood Disorders Transfusion 1, at 1, state: “Blood transfusion in Nigeria is plagued by several challenges, one major challenge associated with the Nigerian National Blood Transfusion Service (NBTS) is the fact that the service is not backed by legislation.”

<sup>603</sup> Erhabor, Adias & Mainasara, *Provision of Safe Blood Transfusion Services in Low Income Setting in West Africa. Case Study of Nigeria* (2013) 59 Advances in Medicine and Biology 1, at 11-12, remark, “Developing countries face considerable obstacles to ensuring a safe blood supply and safe blood transfusions. There is a tendency for developing countries not to have enough available blood so they depend on family blood donors. Family replacement donors are donors who give blood when it is required by a member of the donor’s family or community. ... Being expected to provide replacement donors puts additional responsibility and stress on them, there is undue pressure on members of the family to give blood, even when they know that donating blood may affect their own health or that they may be potentially at risk of transmission of transfusion-transmissible. ... Blood safety remains an issue of major concern in transfusion practice in most countries in sub-Saharan Africa. This is further aggravated by the predominance of commercially remunerated blood donors, rather than regular benevolent, non-remunerated donors who give blood as a result of altruism. ... Previous reports in most countries in sub-Saharan have indicated a high prevalence of transfusion transmissible infections among commercially remunerated blood donors. Commercial remunerated donors often come from the poorest sectors of the economy, may be poor in health, are more likely to give blood more often than recommended, are also at a higher risk of being undernourished and having a transfusion-transmissible infection from high risk behaviours like maintenance of multiple sex partner, intravenous drug abuse and unprotected sexual intercourse.”

life style of many touts would give cause for serious concern. A study<sup>604</sup> of blood donated at the University of Benin Teaching Hospital, 96. 9% of which had been supplied by commercial blood donors, revealed what the researchers discussed as the "alarming"<sup>605</sup> rate of 8% which was affected by syphilis.

As was mentioned in Chapter 1, the weak system of protection for patients in Nigeria has been noticed by foreign corporations, who have cynically sought, on occasion, to exploit the gaps in the law for their financial benefits.<sup>606</sup> A Pfizer's Trovan Test was carried out by US pharmaceutical company in 1996 at Kano. Its outcomes gave rise to ethical and legal questions. It transpired that the company had illegally tested an experimental drug on children suffering from meningitis.<sup>607</sup> The victims of the Trovan test filed a class action against Pfizer both in Nigeria<sup>608</sup> and US. In the US Court of Appeals, Second Circuit in *Abdullahi v Pfizer*,<sup>609</sup> the plaintiffs alleged the defendant had dispatched three of its American physicians to work with four Nigerian doctors to experiment with Trovan on children who were patients in Nigeria's Infectious Disease Hospital in Kano, Nigeria. After the conclusion of the experiment, the defendant left without follow-up care and, as a result, the test caused the deaths of eleven children, as well as severe deformities in

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<sup>604</sup> Adegoke, Akanni & Dirisu, *Risk of transfusion-transmitted syphilis in a tertiary hospital in Nigeria* (2011) 3 N. American J of Med Sciences 78.

<sup>605</sup> *Ibid.*, at 80.

<sup>606</sup> Kristen Farrell, *Human Experimentation in Developing Countries: Improving International Practices by Identifying Vulnerable Populations and Allocating Fair Benefits* (2006) 9 J Health Care L & Pol'y 136, at 136, remarks: "The target populations for clinical research in developing countries often have no access to basic health care, lack an understanding of the research, and are politically powerless. Governments of host nations frequently view research as a way to provide otherwise unaffordable medical care. The sponsors of the clinical trials gravitate to developing countries because of lower costs, the prevalence of diseases, and seemingly limitless numbers of improvised patients."

<sup>607</sup> See generally Remigius N. Nwabueze, *Legal and Ethical Regulation of Biomedical Research in Developing Countries* (Ashgate Publishing Ltd., 2013); Adebola Olufowobi, *Protecting the rights of Children as Human Subjects in Developing Countries: Revisiting Informed Consent* (2014) 544 Law School Student Scholarship 1.

<sup>608</sup> The Nigerian action was settled with no admission of liability on the part of the defendant. Oluwakemi Adekile, *Compensating Victims of Personal Injury in Tort: The Nigerian Experience So Far* (2013) Acta U. Danubius Jur. 144, at 152.

<sup>609</sup> (2009) 562 F.3d 163.

others, including blindness, deafness, paralysis and brain-damage. The defendant sought the dismissal of the claim for failure to state a cause of action under the Alien Tort Statute. The Court of Appeals, Second Circuit held that the plaintiffs were entitled to bring suit against the defendant in US under the Alien Tort Statute<sup>610</sup>, giving effect to international standards that prohibits clinical testing of experimental drugs on human subjects without their consent. The issues against the defendant would turn on the dumping of dangerous products in a developing country with the intention of exploiting the lower "informed consent" requirements to carry out the test.<sup>611</sup> The *Abdullahi* case stressed the importance for pharmaceutical companies, when conducting clinical trials, particularly in the underdeveloped countries, to adhere to the regulatory controls and international standards regarding the protection of the rights of their subjects.<sup>612</sup>

One should acknowledge that there is some regulatory protection for patients and other consumers in Nigeria. This offers the possibility of criminal sanctions. Successful prosecutions were brought against the producers of "My Pikin", an adulterated teething mixture, which caused the deaths of at least 80 children in the

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<sup>610</sup> *Abdullahi v Pfizer* (2009) 562 F.3d 163, at 187, where Barrington D. Parker J stated, "[w]e hold that the plaintiffs have pled facts sufficient to state a cause of action under the ATS for a violation of the norm of customary international law prohibiting medical experimentation on human subjects without their consent. In such an instance, ATS jurisdiction exists over plaintiffs' claim." Cf Stacey B. Lee, *Informed Consent: Enforcing Pharmaceutical Companies' Obligations Abroad* (2010) 12 Health And Human Rights 15, at 24.

<sup>611</sup> Kristen Farrell, *Human Experimentation In Developing Countries: Improving International to Practices By Identifying Vulnerable Populations And Allocating Fair Benefits* (2006) 9 J Health Care L & Pol'y 136, at 140, states: "The *Abdullahi* case and the African trials underscore the legal and ethical dilemmas attached to clinical trials in developing countries. The Nigerian children and their parents never provided truly informed consent, but the subjects of these experiments deserve protection from exploitative studies."

<sup>612</sup> Remigius N. Nwabueze, *Ethical Review of Research Involving Human Subjects in Nigeria: Legal and Policy Issues* (2003) 14 Int'l & Comp L Rev 87, at 102, states, "Nigeria does not have any formal regulatory system of ethics review, or research guideline produced by the country's medical research institutions or governmental agencies that fund medical research. This regulatory deficiency was probably responsible for the "trovan" tragedy in Nigeria. No state or federal statutory enactments in Nigeria directly regulates the conduct of research involving human subjects, though a variety of statues may indirectly impinge on human subject experimentation in Nigeria. It is arguable that the regulatory void in many African countries, including Nigeria, is a deliberate health policy by these countries, geared towards attracting desperately needed biomedical research sponsored by developed foreign countries, multinational corporations, and international organizations."

year 2008.<sup>613</sup> No claims for civil compensation were reported and the civil liability implications of such criminal conduct have yet to be analysed by any Nigerian courts.<sup>614</sup>

### *Product Liability Based on Negligence*

Let us now turn to consider the extent to which the tort of negligence affords protection to patients in relation to products used – either by health service providers or by the patients themselves – in the care or treatment of patients.

The history of the law of negligence in regard to products involves the slow movement from a virtually total immunity to the present position, which places a duty of care on everyone involved in the use of products, from manufacturer to ultimate user.

Formerly, the courts throughout the common law world took the view that liability should not extend outside the contractual nexus. The classic expression of this principle occurred in *Winterbottom v Wright*.<sup>615</sup>

Throughout the 19<sup>th</sup> century and well into the 20<sup>th</sup> century, it was not possible for an injured consumer to sue a negligent manufacturer for the tort of negligence. This was the position in both Britain and the United States of America. The only, limited, exception, where a duty of care arose, was in regard to "inherently" or "imminently" dangerous products (such as gunpowder, for example).

In the United States of America, matters changed radically with the decision of the New York Court of Appeals in *MacPherson v Buick Motor Co.*<sup>616</sup> The defendant

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<sup>613</sup> Vanguard Newspaper (Nigeria), *My Pikin: A case for review of NAFDAC law* (5 June 2013), reports, "National Agency for Food and Drug Administration and Control (NAFDAC), ... in what is regarded as a historic feat, secured ... a court judgment against the producers of My Pikin teething mixture that killed scores of children in 2008. This is the first time the agency would strike the bull's eye in litigation that bother on medicine issue." See also Chukwuemeka Nwoko, *Food Terrorism in Nigeria: Fears, Possibilities and Action* (2011) 4 J of Politics & L 159, at 160.

<sup>614</sup> Okeri & Okeri, *Medicinal Products Liability of the Pharmacists: An Overview of Some Emerging Legal Issues in Nigeria* (2008) 10 World Health & Population 5.

<sup>615</sup> (1842) 10 M & W 109.



was a manufacturer of automobiles. It sold an automobile to a retail dealer. The retail dealer resold to the plaintiff. While the plaintiff was in the car, it suddenly collapsed. He was thrown out and injured. One of the wheels was made of defective wood and its spokes crumbled into fragments. The wheel was not made by the defendant; it was bought from another manufacturer. The plaintiff alleged negligence and brought action for damages. The defendant argued that it was not liable for the wheel manufacturer's negligence.

The New York Court of Appeals considered whether the defendant owed a duty of care and vigilance to any one but the immediate purchaser. The Court of Appeals held that the defendant owed a duty of care to the plaintiff<sup>617</sup>. Cardozo J remarked:

*“We hold, then, that the principle of Thomas v Winchester<sup>618</sup> is not limited to poisons, explosives, and things of like nature, to things which in their normal operation are implements of destruction. If the nature of a thing is such that it is reasonably certain to place life and limb in peril when negligently made, it is then a thing of danger. Its nature gives warning of the consequences to be expected. If to the element of danger there is added knowledge that the thing will be used by persons other than the purchaser, and used without new tests, then, irrespective of contract, the manufacturer of this thing of danger is under a duty to make it carefully.”<sup>619</sup>*

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<sup>616</sup> (1916) 217 N.Y. 382.

<sup>617</sup> *Ibid.*, at 390-391, Cardozo J stated: “... the nature of an automobile gives warning of probable danger if its construction is defective. This automobile was designed to go fifty miles an hour. Unless its wheels were sound and strong, injury was almost certain. It was as much a thing of danger as a defective engine for a railroad. The defendant knew the danger. It knew also that the care would be used by persons other than the buyer. This was apparent from its size; there were seats for three persons. It was apparent also from the fact that the buyer was a dealer in cars, who bought to resell. The maker of this car supplied it for the use of purchasers from the dealer ...”

<sup>618</sup> (1852) 6 N.Y. 397, at 408, Ruggles Ch. J held: “Misfortune to third persons, not parties to the contract, would not be a natural and necessary consequence of the builder's negligence; and such negligence is not an act imminently dangerous to human life.”

<sup>619</sup> *MacPherson v Buick Motor Co* (1916) 217 N.Y. 382, at 389.

This decision marks a judicial landmark in giving third parties who have suffered damage the right to recover in the tort of negligence from manufacturers even without the existence of a contractual relationship. Cardozo J seized on the normative basis for imposing a duty of care in respect of "things of danger", such as gunpowder, to hold that such normative basis should extend to every product, however benign when safely made, which carries the risk of injuring the consumer as a result of negligence in its manufacture.

In Britain, the crucial judgment abandoning *Winterbottom v Wright*<sup>620</sup> is *Donoghue v Stevenson*,<sup>621</sup> decided in 1932, 16 years after the New York decision of *MacPherson v Buick Motor Co.*<sup>622</sup> This case is the most celebrated decision of British tort law. The facts are so well known that they may be summarised very briefly. The pursuer drank a bottle of ginger beer, manufactured by the defender, which a friend had bought from a retailer and given to her. The bottle contained the decomposed remains of a snail which were not and could not be detected until the greater part of the contents of the bottle had been consumed. The pursuer alleged negligence and brought action for damages.

The House of Lords, by a majority of three<sup>623</sup> to two<sup>624</sup>, held that a manufacturer of chattels might in some circumstances owe a duty of care to the ultimate consumer.

The leading speech<sup>625</sup> is that of Lord Atkin who stated:

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<sup>620</sup> (1842) 10 M & W 109.

<sup>621</sup> [1932] 1 AC 562.

<sup>622</sup> (1916) 217 N.Y. 382.

<sup>623</sup> Lord Atkin, Lord MacMillan, and Lord Thankerton.

<sup>624</sup> Lord Buckmaster and Lord Tomlin.

<sup>625</sup> The importance of Lord Atkin's speech lies in the fact that he articulated a general principle for determining the duty of care. Formerly, courts had not recourse to an overarching principle and decided the duty of care issue on an *ad hoc*, highly contextualised, basis. Lord Atkin (at 580), stated:

*"The rule that you are to love your neighbour becomes in law, you must not injure your neighbour; and the lawyer's question 'Who is my neighbour?' The answer seems to be – persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as*

*“[A] manufacturer of products, which he sells in such a form as to show that he intends them to reach the ultimate consumer in the form in which they left him with no reasonable possibility of intermediate examination, and with the knowledge that the absence of reasonable care in the preparation or putting up of the products will result in an injury to the consumer’s life or property, owes a duty to the consumer to take reasonable care.”*<sup>626</sup>

The duty of care under *Donoghue v Stevenson*<sup>627</sup> has been extended beyond manufacturers to others who exercise control over a product, including assemblers<sup>628</sup>, repairers<sup>629</sup>, suppliers<sup>630</sup> and retailers<sup>631</sup>.

Courts have not restricted their interpretation of the concept of a “product” to food and drink but have included any item capable of causing physical injury or damage.<sup>632</sup>

The Courts have extended the scope of duty owed to “ultimate consumers” to include persons who do not “consume” or use the product in any way but rather are third parties who are nonetheless foreseeably at risk of being injured by it, such as an employee of the purchaser,<sup>633</sup> or a by-stander<sup>634</sup>.

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*being so affected when I am directing my mind to the acts or omissions which are called in question.”*

<sup>626</sup> *Donoghue v Stevenson* [1932] 1 AC 562, at 599.

<sup>627</sup> *Ibid.*

<sup>628</sup> *Howard v Furness Houlder Ltd* [1936] 2 All ER 781.

<sup>629</sup> *Herschtal v Stewart & Arden Ltd* [1940] 1 KB 155; *Haseldine v Daw* [1941] 2 KB 343.

<sup>630</sup> *Keegan v Owens* [1953] IR 267.

<sup>631</sup> *Andrews v Hopkinson* [1957] 1 QB 229.

<sup>632</sup> Such as underpants: *Grant v Australian Knitting Mills Ltd* [1936] AC 85; kiosks: *Paine v Colne Valley Electricity Supply Co* [1938] 4 All ER 803, cars: *Herschtal v Stewart & Arden Ltd* [1940] 1 KB 155, hair-dye: *Watson v Buckley* [1940] 1 All ER 174, lifts: *Haseldine v Daw & Son Ltd* [1941] 2 KB 343, and industrial chemicals: *Vacwell Engineering Co Ltd v B. D. H. Chemicals Ltd* [1971] 1 QB 88.

<sup>633</sup> *Davie v New Merton Board Mills Ltd* [1959] AC 604.

<sup>634</sup> *Stennett v Hancock* [1939] 2 All ER 578; *O’Sullivan v Noonan* (28 July 1972) SC.

In Nigeria<sup>635</sup>, and indeed in other African countries,<sup>636</sup> the overwhelming majority of cases in which product liability issues have been considered involve items of food or drink in which manufacturers are advancing the defence of a "foolproof" system of production following the discovery of some injurious defect or presence of a foreign object in the product.<sup>637</sup> A representative example is *Osemobor v Niger Biscuit Co Ltd*.<sup>638</sup> The plaintiff purchased at supermarket a packet of biscuits manufactured and packed by the defendants. In the course of chewing, she discovered a decayed tooth; as a result she took ill and sought medical treatment. The High Court of Lagos State held the defendants liable in negligence. Kassim J stated:

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<sup>635</sup> The Nigerian courts, in deciding liability for negligence have cited with approval the underlying principles in the *Donoghue's* case as reference in negligence actions in general and product liability in particular. See generally: Jill Cottrell, *The Tort of Negligence in Nigeria* (1973) 17 Journal of African Law 30. In *Ogbidi v Guinness (Nigeria) Ltd* [1981] 1 FNLR 67 (HC), the plaintiff alleged that the Harp lager beer which he drank contained some black sediments which caused him illness. The court held that there must be proof that the product reached the consumer in the same state as it and left the manufacturer with no reasonable possibility of intermediate examination by the retailer or consumer. Gbemudu J (at 70) stated: "The principle of *Donoghue's* case can only be applied where the defect is hidden and unknown to the consumer, otherwise the directness of cause and effect is absent." See also *Nigerian Bottling Co Ltd v Ngonadi* (1985) NWLR (Pt. 4) 739; *Ebelamu v Guinness (Nigeria) Ltd* [1983] 1 FNLR 42; *Okonkwo v Guinness (Nig) Ltd* (1980) 1 PLR 538; *Boardman v Guinness (Nig) Ltd* (1980) NCLR 109. In *Nigerian Bottling Co Plc v Olarewaju* [2007] 5 NWLR 255, the plaintiff bought two bottles of Coca-cola, a product of the defendant. He drank a bottle of the product half-way before he noticed some particles in the bottle and saw similar particles in the unopened bottle. He became unwell and visited a hospital for treatment. The question of whether the doctrine of *res ipsa loquitur* applies in food poisoning was examined by the Court of Appeal. It was the opinion of the Court that the plaintiff had to discharge both legal and evidential burdens of proof. Ogunwumiju JCA (267-268) stated: "The doctrine of *res ipsa loquitur* does not apply in food poisoning cases. There is no law to the effect that if *A* consumes rice and he thereafter feels stomach discomfort, then viola! The rice is the cause of the discomfort. There must be more direct and positive proof of the cause of the discomfort. The onus placed on the plaintiff to establish a *nexus* between the consumed coke and his ailment was not in my view discharged on a balance of probabilities." See *Okonkwo v Guinness (Nig) Ltd* (1980) 1 PLR 538; *Boardman v Guinness (Nig) Ltd* (1980) NCLR 109; *Nigerian Bottling Co Ltd v Ngonadi* (1985) NWLR (Pt. 4) 739; *Nsima v Nigerian Bottling Co Ltd* (2014) LPELR-22542 (CA).

<sup>636</sup> See, eg, *Kenya Breweries Ltd v Godfrey Odoyo* [2010] eKLR; *Kalemera Godfrey & Ors v Unilever (U) Ltd* [2008] UGHC 23; *Overseas Breweries Ltd v Acheampong* [1973] 1 GLR 421.

<sup>637</sup> Onyekachi A. Otisi, *Products Liability In Nigeria: The Tort Aspect* (1991) 2 Justice: A Journal of Contemporary Legal Problems 63, at 75, the author observes: "Judicial decisions, within Nigeria particularly, tend to confine *res ipsa loquitur* to physical injury or road accident cases. Although in products liability, judicial decisions have shown that where negligence can be attributed to the manufacturer that the court would infer negligence in his part, there still a reluctance to extend the maxim to products liability cases expressly."

<sup>638</sup> (1973) 7 CCHCJ 71.

*“I am satisfied that there was no probability of an intermediate examination of the biscuits before they reached the plaintiff, and I find myself unable to uphold the submission of the learned counsel for the defendants that she was bound to look at the biscuits before she put them in her mouth. ... A person who manufactures goods, which he intends to be used or consumed by others, is under a duty to take reasonable care in their manufacture, so that they can be used or consumed in the manner intended, without causing physical damages to person or property.”<sup>639</sup>*

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<sup>639</sup> *Ibid.*, at 72. In *Edward Okwejiminor v Gbakeji & Anor* (1998) 8 NWLR (Pt. 561) 295, the Court of Appeal, Benin Judicial Division, held that the onus was on the plaintiff to discharge the burden of proving the assertion that the Fanta he drank caused his illness. In this case, the learned Justices of the Court of Appeal appeared to have demanded a high standard of proof from the complainant in food poisoning cases. The Court of Appeal stated: “Thus there must be proven direct link between the food/drink ingested and the subsequent ailment of the complainant. I have no reason to disagree with this stand. To make the standard of proof less might open a floodgate of litigation based on spurious and untrue assertions against manufacturers. This would have the reverse effect of defeating the very mischief sought to be cured by placing a burden of care on manufacturers of consumables. As opined earlier, there is high standard of advancement in technology in Nigeria to enable a genuine person aggrieved by the negligence of multinational companies to affix liability on them by linking their products directly with the ailment complained of.” The doctrine of *res ipsa loquitur* applies where foreign objects like cockroaches or flies are present in the food, regardless of their source. The Supreme Court of Zambia considered the effect of negligence in *Zambian Breweries Plc v Reuben Mwanza* [2000] ZLR 12. The plaintiff bought a bottle of castle larger beer manufactured by the defendant. He drank half of the contents of the beer and felt uncomfortable; on examination of the bottle he found that it contained a dead lizard. Chirwa JS (at 14), stated: “It is not normal to find lizards in beer bottles and also to find that people carry dead lizards in order to throw them in beer bottles would require strong evidence.” It will be a welcome development for Nigerian courts if strict liability is imposed through legislation on manufacturers as it applied in other jurisdictions. Oluwakemi Adekile, *Compensating Victims of Personal Injury in Tort: The Nigerian Experience So Far* (2013) 9 AUDJ 144, at 154, states: “The imperative for a strict product liability is that public policy demands that responsibility be fixed whenever it will most effectively reduced the hazards of life and health inherent in defective products that reach the market. It is apparent that the manufacturer can anticipate some hazards and guard against the occurrence of others, as the public cannot. Those who suffer injury from defective products are unprepared to meet its consequence. What option presents itself to Nigeria in the face of the inadequacy? It is acknowledged that strict product liability regime is fascinating and has instrumental value that promotes safety and improves standards. It is however clear from the statement of the court ... that the courts in Nigeria are not disposed to readily find manufacturers liable for product defect. Perhaps the take off point for tort reform should be in a reputable presumption of infraction of duty against the manufacturer in the light of the suggestion in *Okonkwo’s* case.” Odigie & Odion, *The Impact of Consumers’ Protection Laws and the Regulatory Schemes in Nigeria* (2011) 2 Int’l J of Advanced Legal Studies and Governance 140, at 144, argue for the application of strict liability, state: “The courts should adopt a strict liability approach to cases of product liability and food poisoning cases as it is done in other jurisdictions.” Paul Samuel Tamuno, *Negligence Versus Strict Liability: In the Fight Against Environmental Degradation in the Niger Delta of Nigeria* (2011) Centre for Energy, Petroleum & Mineral Law & Policy – Research Network: Working Paper Series No.2011/01.

One may speculate as to why so many cases in Nigeria and other African countries involve food and drink products and so very few involve products of a different kind. One reason, distinctively relating to drink products, is that there is a practice among manufacturers of using recycled bottles for which payments are made.<sup>640</sup> Those who offer bottles for recycling to manufacturing companies are unscrupulous about their provenance and can resort even to public dumps to find them. A second reason is that, where food and drink products are concerned, the expectations of consumers are unambiguous and proof of a defect is usually straightforward, provided the court accepts the credibility of the plaintiff's evidence. Once a defect is established, the manufacturer, in practice, will find it hard to convince the court that it had adopted a reasonable process of manufacture.<sup>641</sup>

### *Strict Product Liability Regimes*

Let us now turn to consider how courts and legislatures in many countries over the past half century have embraced a strict liability regime for product defects, which offers consumers a remedy without the requirement of proving negligence on the part of the manufacturer.

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<sup>640</sup> Cf Andoh, Fiagbe, Davis & Asaana, *A Mathematical Model To Predict The Quantity Of Defective Bottles In An Automated Bottle Washer Using Factorial Design Technique* (2013) 2 Int'l J of Scientific & Technology Research 56, at 56, states: "[I]mproper wash[ing] of reused bottles in beer and soft drink production plants can result in [a] potentially dangerous health hazard to consumers. It is shown that when machines are used over a periods of time, they are not able to perform at their best, for which there are many root causes."

<sup>641</sup> William L. Prosser, *Res Ipsa Loquitur in California* (1949) 37 Cal. L Review 183, at 227-228, states: "The defendant testifies that he operated his bakeshop with all possible care; but the fact remains that glass does not get into bread in carefully operated bakeries. He testifies that there was no negligence in running his train; but still it went off the track. He testifies that he inspected his elevator; but properly inspected elevators do not fail. He says that he parked his car safely; but there is the car, coming down the hill. He says that he examined his gas pipes after the explosion and found no leak; but gas pipes which do not leak do not explode. He says that he put a weight in such a position that it could not possibly have fallen; nevertheless it fell. He says that his permanent wave machine was handled with such extraordinary care and foresight that no one could possibly have been burned by it; but here is the plaintiff who was burned. In all such cases there is common experience which permits the jury to conclude that the defendant's witness are not to be believed, that something went wrong with the precautions described, that the full truth has not been told. As defendant's evidence approaches conclusive proof that such precautions were taken that this accident could not possibly have occurred, it is all the more obviously contradicted by the fact that it did occur."

The prologue may be considered to be Traynor J's concurring judgment in the Supreme Court of California in *Escola v Coca Cola Bottling Co.*<sup>642</sup> The plaintiff, a waitress in a restaurant, was injured when a bottle of Coca Cola broke in her hand. She allegedly that defendant company, which had bottled and delivered the alleged defective bottle to her employer, was negligent in selling "bottles containing said beverage which on account of excessive pressure of gas or by reason of some defect in the bottle was dangerous ... and likely to explode." The plaintiff pleaded and proved *res ipsa loquitur* and this plea proved successful for most members of the Court.

However, Traynor J in his concurring judgment expressed the view that strict liability should be the appropriate test. He stated:

*"In my opinion it should now be recognized that a manufacturer incurs an absolute liability when an article that he has placed on the market, knowing that it is to be used without inspection, proves to have a defect that causes injury to human beings."*<sup>643</sup>

Traynor J provided three policy rationales for the theory of strict liability: first, it encourages a manufacturer to structure its organization with adequate supervision for effective delivery of quality products<sup>644</sup>. Secondly, making the manufacturer strictly liable can spread the cost of production onto all consumers<sup>645</sup>. Lastly, strict

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<sup>642</sup> (1944) 24 Cal.2d 453; 150 P.2d 436.

<sup>643</sup> *Escola v Coca Cola Bottling Co* (1944) 24 Cal 2d 453; 150 P 2d 436, at 440.

<sup>644</sup> *Ibid.*, at 440-441, Traynor J stated: "Even if there is no negligence, ... public demands that responsibility be fixed wherever it will most effectively reduce the hazards to life and health inherent in defective products that reach the market. It is evident that the manufacturer can anticipate some hazards and guard against the recurrence of others, as the public cannot."

<sup>645</sup> *Ibid.*, at 441, Traynor J stated: "Those who suffer injury from defective products are unprepared to meet its consequences. The cost of an injury and the loss of time or health may be an overwhelming misfortune to the person

liability eliminates the requirements of proof often confronted by plaintiffs<sup>646</sup>. Traynor J stated:

*“In leaving it to the jury to decide whether the inference has been dispelled, regardless of the evidence against it, the negligence rule approaches the rule of strict liability. It is needlessly circuitous to make negligence the basis of recovery and impose what is in reality liability without negligence. If public policy demands that a manufacturer of goods be responsible for their quality regardless of negligence there is no reason not to fix that responsibility openly.”*<sup>647</sup>

Traynor J was for two decades a voice crying in the wilderness, but radical change was to come in the 1960s. The first step in the process involved an extension of the implied warranty of merchantability. In *Henningsen v Bloodfield Motors, Inc*<sup>648</sup>, the New Jersey Supreme Court held that car manufacturers could not exclude such a warranty, which extended to ultimate consumers. While using the language of contract, the practical outcome of this decision was to impose strict liability on manufacturers to third parties.

The second, decisive, step was taken by the Supreme Court of California in *Greenman v Yuba Power Products, Inc.*<sup>649</sup> In this case, Traynor J, a veteran of the Court, now succeeded in convincing his colleagues that it was the time to articulate

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injured, and a needless one, for the risk of injury can be insured by the manufacturer and distributed among the public as a cost of doing business. It is to the public interest to discourage the marketing of products having defects that are menace to the public. If such products nevertheless find their way into the market it is to the public interest to place the responsibility for whatever injury they may cause upon the manufacturer, who, even if he is not negligent in the manufacture of the product, is responsible for its reaching the market.”

<sup>646</sup> *Ibid.*, at 441, Traynor J stated: “An injured person, . . . is not ordinarily in a position to refute such evidence or identify the cause of the defect, for he can hardly be familiar with the manufacturing process as the manufacturer himself is.”

<sup>647</sup> *Escola v Coca Cola Bottling Co* (1944) 24 Cal 2d 453; 150 P 2d 436, at 442.

<sup>648</sup> (1960) 32 N. J 358; 161 A.2d 69.

<sup>649</sup> (1963) 59 Cal.2d 57.



frankly a test of strict liability in tort.<sup>650</sup> Reiterating the policy arguments that he had advanced two decades previously in *Escola*, Traynor J observed:

*“The purpose of such liability is to insure that the costs of injuries resulting from defective products are borne by the manufacturers that put such products on the market rather than by the injured persons who are powerless to protect themselves. Sales warranties serve this purpose fitfully at best.”*<sup>651</sup>

In Europe, what was then the European Economic Community (EEC) adopted a Directive<sup>652</sup> on Product Liability in 1985. The Directive, clearly inspired by developments in the United States of America, imposes liability on producers<sup>653</sup> for damage caused by a defective product. The core position is Article 6, which provides, in paragraph 1:

“A product is defective when it does not provide the safety which a person is entitled to expect, taking all circumstances into account, including: (a) the presentation of the product; (b) the use to which it could reasonably be expected that the product would be put; (c) the time when the product was put into circulation.”

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<sup>650</sup> However, the Zambia High Court in *Nyasulu & Ors v Konkola Copper Mines Plc & Ors* [2011] 1 ZLR 47, where an action was initiated by 2000 plaintiffs who are residents in Chingola, and whose source of water is a stream in which the first defendant was discharging effluence from its mining operations. Musonda J (at 55) distinguished environmental tort from product liability, stated: “Let me ... draw a distinction between negligence where something escapes and does harm. And product liability where a product for consumption is released on the market and does harm. These are two different concepts. The case of *Greenman v Yunba Power Products, Inc* (1963) 59 Cal.2d 57, ... is out of context.”

<sup>651</sup> *Greeman v Yuba Power Products, Inc* (1963) 59 Cal. 2d 57, at 63-64.

<sup>652</sup> Council Directive 85/374/EEC of July 1985 on the approximation of the laws, regulations and administrative provisions of the Member States concerning liability for defective products.

<sup>653</sup> As well as importers into the Community, “own-branders” and retailers who do not disclose the provenance of the defective product.

A limited range of defences is prescribed in Article 7<sup>654</sup>, the most significant of which is the "development risks" defence, which protects a producer of a product where the state of scientific and technical knowledge at the time the product was put into circulation was not such as to enable the existence of the defect to be discovered.

In *A v National Blood Authority*,<sup>655</sup> Burton J adopted a stringent test for defectiveness under the Product Liability Directive. The product in question was blood, which had been used in transfusions to the 114 plaintiffs, causing them to be infected with the Hepatitis C virus. At the time, those involved in transfusing blood were aware that there was a small possibility, with regard to *all* blood transfused, that the virus would be present; there was no way, however, to prevent this possibility. Patients were not generally informed of this risk.

The defendants argued that the test for defectiveness was one of legitimate expectation on the part of the consumer: in view of the impossibility of avoiding the risk of infection, no consumer could legitimately expect a level of safety higher than that which could actually be achieved. Burton J disagreed. In his view, adoption of tests of avoidability or of legitimately expectable safety precautions

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<sup>654</sup> It provides that the producer shall not be liable if he proves: (a) that he did not put the product into circulation; or (b) that, having regard to the circumstances, it is probable that the defect which caused the damage did not exist at the time when the product was put into circulation by him or that this defect came into being afterwards; or (c) that the product was neither manufactured by him for sale or any form of distribution for economic purpose nor manufactured or distributed by him in the course of his business; or (d) that the defect is due to compliance of the product with mandatory regulations issued by the public authorities; or (e) that the state of scientific and technical knowledge at the time when he put the product into circulation was not such as to enable the existence of the defect to be discovered; or (f) in the case of a manufacturer of a component, that the defect is attributable to the design of the product in which the component has been fitted or to the instructions given by the manufacturer of the product. (Clause (e) is optional but many states have included it when implementing the Directive.)

<sup>655</sup> [2001] 3 All ER 289, analysed by Howells & Mildred, *Infected Blood: Defect and Discoverability A First Exposition of the EC Product Liability Directive* (2002) 65 Modern L Rev 95; Hodges C, *Compensating Patients* (2001) 117 LQ Rev 528.

would inevitably involve a substantial investigation, which would unduly dilute the strict liability regime that the Directive was designed to achieve:

*“What safety precautions or tests were available or reasonably available? Were they tests that would have been excessively expensive? Tests which would have been more expensive than justified the extra safety achieved? Are economic or political circumstances or restrictions to be taken into account in legitimate expectability? Once it is asserted that it is legitimately expectable that a certain safety precaution should have been taken, then the producer must surely be able to explain why such was not possible or why he did not do it; in which case it will then be explored as to whether such tests would or could have been carried out, or were or would have been too expensive or impracticable to carry out. If risk and benefit should be considered, then it might be said that, the more beneficial the product, the lower the tolerable level of safety; but this could not be arrived at without consideration as to whether, beneficial or not, there would have nevertheless been a safer way of setting about production or design ...”<sup>656</sup>*

The “development risks” defence was thus unsuccessful. Burton J considered that the defendant could not show that the state of scientific and technical knowledge had been such as to render it impossible to be aware of the defect: the defendant was aware of the defect but was not in a position to remedy it. The fact that scientifically it was impossible to render a product safe was a quite different matter from the scientific impossibility of becoming aware that a product was defective.

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<sup>656</sup> *A v National Blood Authority* [2001] 3 All ER 289, at para 58.

Burton J's judgment is generally regarded as involving a very "pro-plaintiff" approach towards the questions of defectiveness and the scope of the development risk defence. It seems likely that Burton J had regard to the fact that the case involved the provision of a health service to the general public. The public policy dimension thus loomed large.

A number of countries have followed the lead of the United States and Europe and have adopted regimes of strict liability for defective products on the manufacturers and others in the supply or distribution chain of the products.<sup>657</sup> Australia's Competition and Consumer Act 2010<sup>658</sup> imposes statutory a strict liability on manufacturers.<sup>659</sup> Russia has moved in the same direction but its product liability regime is not contained in a single statute: it operates both tort of negligence<sup>660</sup> and strict liability<sup>661</sup> regardless of contractual relationships.<sup>662</sup> Japan's Product Liability Act 1994<sup>663</sup> also imposes strict liability on manufacturers<sup>664</sup>. In Taiwan, as in Britain and Ireland, there is a disparity of liability between manufacturers and distributors. A manufacturer may be held strictly liable under the Consumer Protection Act 1994<sup>665</sup> and also presumed to be negligent under the tort of the Civil Code 1929, as amended in 2014<sup>666</sup> while a distributor in the same position may be

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<sup>657</sup> See generally, Davis Varner & Bradley W Pratt eds, *The Product Regulation and Liability Review* (Law Business Research Ltd, 2014).

<sup>658</sup> Part VA – Liability of manufacturers and importers for defective goods.

<sup>659</sup> See Loveday, Cook & Birch, "Australia", Chapter 1 of C Davis Varner & Bradley W Pratt eds, *The Product Regulation and Liability Review* (Law Business Research Ltd, 2014) 1, at 3.

<sup>660</sup> See Article 1064(2) of the Civil Code: General Grounds for Liability for Damage.

<sup>661</sup> See Article 1095 of the Civil Code: The Grounds for the Redress of Injury Inflicted by Defects in Goods, Works and Services.

<sup>662</sup> See Sergey Yuryev, "Russia", Chapter 12 of C Davis Varner & Bradley W Pratt eds, *The Product Regulation and Liability Review* (Law Business Research Ltd, 2014) 117, at 120.

<sup>663</sup> See Behrens & Raddock, *Japan's New Product Liability Law: The Citadel Of Strict Liability Falls, But Access To Recovery Is Limited By Formidable Barriers* (1995) 16 U. Pa. Int'l Bus. L 669, at 689; Hironaka, Kawabata & Haruyama, "Japan", Chapter 9 of C Davis Varner & Bradley W Pratt eds, *The Product Regulation and Liability Review* (Law Business Research Ltd, 2014) 92, at 102.

<sup>664</sup> See Article 3 (Product Liability).

<sup>665</sup> See Article 7.

<sup>666</sup> See Article 184.

held to be negligent under CPA.<sup>667</sup> In Thailand,<sup>668</sup> the concept of strict liability was adopted in the Liability for Damages Arising from Unsafe Products Act 2008<sup>669</sup>.

In South Africa, the Supreme Court of Appeal in *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd*,<sup>670</sup> declined to impose strict liability in a delictual claim on a manufacturer of defective products except by legislation. The plaintiff had undergone shoulder surgery. The procedure involved administration of a local anaesthetic, which resulted to necrosis and paralysis of her right arm. The plaintiff claimed that the product was unsafe for use as a local anaesthetic. She argued that it was necessary for the Court to apply a strict liability regime in order to vindicate her constitutional right to body integrity. The Court rejected this argument. Howie J stated:

*“[T]he plaintiff’s remedy is confined to the Aquilian action which is presently adequate to protect her right to bodily integrity, both as it is and given the opportunity for incremental development of the approach to res ipsa loquitur and to the incidence of the onus. If strict liability is to be imposed it is the legislature that must do it.”*<sup>671</sup>

The legislature responded to this implicit invitation and enacted the Consumer Protection Act 2008<sup>672</sup> which provides for strict liability for manufacturers and retailers for harm caused by their products.<sup>673</sup>

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<sup>667</sup> See Niu, Juang, Lee & Li, *Product Liability – Taiwan* (2014) 1<sup>st</sup> ed, European Lawyer Reference 1, at 2.

<sup>668</sup> See Baker & McKenzie, *Doing Business in Thailand* (Baker & McKenzie Ltd, 2015) 1, at p 84.

<sup>669</sup> See Section 6.

<sup>670</sup> [2003] ZASCA 30.

<sup>671</sup> *Ibid.*, at para 38. In a similar approach, the Supreme Court of Ireland declined to change the onus of proof in *Hanrahan v Merck Sharp & Dohme (Ireland) Ltd* [1988] IESC 1.

<sup>672</sup> See Section 61(1).

China adopted strict liability in the Law of the People's Republic of China on Product Quality 1999<sup>674</sup>, which was reinforced and extended by the Tort Liability Law of the People's Republic of China 2010<sup>675</sup>.

In Brazil, strict liability is applied irrespective of fault under the Consumer Defence Code 1990<sup>676</sup>. The burden of proving defect shifts on the defendant having regard to paragraph 3(ii) of the CDC. In Argentina, product liability is regulated under both the Civil Code 1871<sup>677</sup> and Consumer Protection Act 1993<sup>678</sup>, although there is a Bill pending at the National Congress to reconsider the differences between contractual liability and non-contractual liability which provides strict liability in both cases.<sup>679</sup>

Nigeria has not yet taken the step to strict liability for products. It might be predicted that, if it did so, not a great deal of change would be likely to occur on the ground. Certainly the experience in Europe has been that the Directive of 1985 did not change the legal culture. Nevertheless, it may be argued that a strict liability regime in Nigeria would be of benefit to patients in the healthcare environment. At present, the courts are most reluctant to impose liability, either on manufacturers or healthcare providers, where a patient is injured by a medical product, such a broken needle. A strict liability regime might encourage courts to impose liability where at present their stance is supine.

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<sup>673</sup> See Monray Marsellus Botha, *Does the Consumer Protection Act 68 of 2008 Provide for Strict Product Liability? – A Comparative Analysis* (2011) 74 *Journal of Contemporary Roman-Dutch Law* 305, at 313.

<sup>674</sup> See Article 41.

<sup>675</sup> See Chapter V Product Liability. See further Ip & Marshall, *Evolution of Chinese Consumer Protection: Through the lens of product quality laws* (2014) 26 *Bond L Rev* 35.

<sup>676</sup> See Article 12.

<sup>677</sup> Section 1113.

<sup>678</sup> Section 40.

<sup>679</sup> See Alejandro Martinez de Hoz, *Consumer Protection and Product Liability: Looking for a safe path* (Estudio Beccar Varela Press 2012).

The present regime is far from ideal. The position of hospitals and medical personnel in relation to products used for the medical care of patients raises particular issues in Nigeria, where patients generally have the responsibility for purchasing products, such as needles or drugs, which are to be used in their care. In *Ojo v Gharoro*,<sup>680</sup> it appears that the plaintiff had supplied the surgical needle that was used in an operation on her<sup>681</sup>. The needle broke during the operation and the plaintiff sued for negligence in regard to the alleged failure of the medical personnel to have coped adequately with that problem. The doctor gave evidence which was recorded as follows:

“It is not true that the needle ... got broken negligently. Needles get broken from time to time in operations. With the quality of needles now available, needles get broken more often. No doctor breaks a needle negligently or intentionally. ...”<sup>682</sup>

In cross-examination, the doctor stated:

“A surgical needle is not a strong tool. It breaks or snaps easily. ...”<sup>683</sup>

The Court of Appeal interpreted the doctor’s evidence as amounting to:

“... a general statement on the quality of needles which now abound in shops. [The doctor] did not say substandard needles were used during the operation on the [plaintiff].”<sup>684</sup>

Although counsel for the plaintiff argued, on appeal to the Supreme Court, that the doctor’s evidence had “inferentially pointed conclusively to the use of a

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<sup>680</sup> [2006] 10 NWLR 173.

<sup>681</sup> *Ibid.*, at 222: In their defence, the defendants averred that the plaintiff had bought the surgical needles and other materials that were used for the operation; moreover, they averred that all the drugs administered on her throughout her stay in the hospital had been bought by her.

<sup>682</sup> *Ibid.*, at 205.

<sup>683</sup> *Ibid.*, at 206.

<sup>684</sup> *Ibid.*, at 207.

substandard surgical needle”<sup>685</sup>, he failed to convince the judges of the Supreme Court, who preferred the interpretation given that evidence by the Court of Appeal.

Tobi JSC observed:

*“[The doctor] made a general statement on the quality of surgical needles in shops. He did not say that the needle used for the operation on the [plaintiff] was substandard.”*<sup>686</sup>

Tobi JSC did go on, however, to make the following important *obiter dictum*:

*“Let me take the opportunity to say one last word on the quality of surgical needles. The [doctor], a Consultant, said under cross-examination that a surgical needle is not a strong tool. It breaks or snaps easily. This worries me. It is sad that an instrument for operation of (sic) the human being is not strong enough that ‘It breaks or snaps easily’. It is surprising that an instrument which goes into a human body is not strong enough. I seem to be repeating myself and I have no apologies for that. I think something must be done and very urgently. The medical profession must invent surgical needles that will stand the test of time to ensure that they do not ‘break or snap easily’.”*<sup>687</sup>

Tobi JSC’s observations are of particular interest in the context of product liability principles because he appears to envisage a duty of care resting on “the medical profession” to “invent” surgical needles that do not carry the risk of breaking easily. It is curious that he should regard this task as resting on doctors rather than on

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<sup>685</sup> *Ibid.*

<sup>686</sup> *Ojo v Gharoro* [2006] 10 NWLR 173, at 207-208.

<sup>687</sup> *Ibid.*, at 208.



manufacturers of medical devices. Doctors surely have no distinctive expertise in inventing or producing medical products. But they do have an important role in monitoring the use of such products and in choosing to use particular products and reject others on the basis of considerations of safety.

In Nigeria, where patients tend to purchase and supply these products, there is surely a solemn obligation resting on healthcare providers to take reasonable steps to ensure that patients make purchases that are not likely to cause them injury. Doctors in such circumstances are not passive witnesses to the purchases made by patients. Their relationship with their patients is such as to generate a duty of care on their part to monitor the products and not to use ones that are dangerous. Indeed, that duty arguably extends to advising patients in advance of purchase as to where to make the purchase (and where not to make it) and on to what precise product they should buy.

### *The Broader Constitutional and Human Rights Framework*

At this point, it may be useful to consider the operation of product liability in relation to healthcare in the broader constitutional and human rights framework.<sup>688</sup> There is a growing appreciation internationally that consumer protection should be regarded as an aspect of human rights protection: clearly the rights to life, bodily integrity and health<sup>689</sup> are implicated but also the rights to autonomy, dignity and equality. Increasingly, one finds constitutions containing specific guarantees of

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<sup>688</sup> Eze G, *Consumer Rights as Constitutional Rights – A Comparative Analysis of Some Selected Jurisdiction* (2011) 2 African Journals Online 184, at 190, states: “There is a strong link between consumer protection and human rights. Consumer protection law emerged in the 1970s in response to problems engendered by mass production and market failure. Human rights law recognizes that everyone is entitled to a social and international order in which his rights and freedoms can be fully realized. Enjoyment of human rights depends on production and distribution of scarce goods and services whose availability, quality and accessibility can be increased through international trade.”

<sup>689</sup> In *Purohit & Anor v The Gambia* (2003) AHRLR 96, the Commission examined the various rights guaranteed by the African Charter, it stated (at para 80): “[t]his right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind.”

consumer protection: in Portugal<sup>690</sup>, Spain<sup>691</sup>, Switzerland<sup>692</sup>, the Philippines<sup>693</sup> and Timor-Leste<sup>694</sup>, for example.

Nigeria has no such provisions in its Constitution. If it were to incorporate one, the benefits for consumers would be considerable. Indeed, Nigeria's constitutional structure and underlying philosophy are congenial to such development as the principle of the horizontal application of constitutional rights has been acknowledged by the courts of Nigeria<sup>695</sup> (as also in South Africa<sup>696</sup>, Canada<sup>697</sup>, and Ireland<sup>698</sup> for example). In the Nigerian case of *Abdulhamid v Akar & Anor*,<sup>699</sup> the Supreme Court assessed the enforcement of fundamental rights guaranteed in Chapter IV of the 1979 Constitution, involving private individuals. Akinola Akintan JSC stated:

*“The position of the law is that where fundamental rights are invaded*

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<sup>690</sup> 1982 Constitution, Article 76.

<sup>691</sup> 1978 Constitution, Article 51(1) and 51(2).

<sup>692</sup> 1999 Constitution, Article 97.

<sup>693</sup> 1987 Constitution, Article XVI, General Provision, Section 9.

<sup>694</sup> Constitution of East Timor (2002): Consumer Rights – Section 53(1), states: “Consumers have the right to goods and services of good quality, to truthful information and protection of their health, safety and economic interests, and to reparation for damages.”

<sup>695</sup> 1999 Constitution, s. 6(6)(b): The judicial powers vested in accordance with the foregoing provisions of this section – Shall extend to all matters between persons, or between government or authority and to any person in Nigeria, and to all actions and proceedings relating thereto, for the determination of any question as to the civil rights and obligation of that person. In *Onwo v Oko* [1996] 6 NWLR 584, at 612, the Nigerian Court of Appeal examined the provision of s. 6(6)(b) in the context of its application between *persons*. Ejiwunmi JCA observed that: “the provisions ... do not preclude a person from suing another person who is alleged to be in breach of fundamental human rights of the person who commenced the action.”

<sup>696</sup> In *Khumalo & Ors v Holomisa* [2002] ZACC 12, the South African Constitutional Court examined s. 8 of the Constitution in the context of defamation. The defendants excepted to the plaintiff's claim, arguing that the statement were matters in the public interest, failure to allege the statement was false rendered the claim exculpable in that it failed to disclose cause of action. The Court was of the opinion that the right to freedom of expression is of direct horizontal application in this case in terms of s. 8(2) of the Constitution. However, O'Regan J (at para 39) stated: “[I]n the absence of a defence of reasonable publication, does cause ‘a chilling effect’ on the publication of information. A publisher will think twice before publishing a defamatory statement where it may be difficult or impossible to prove the truth of that statement and where no other defence to defamation would be available.”

<sup>697</sup> *RWDSU v Dolphin Delivery Ltd* [1986] 2 SCR 573.

<sup>698</sup> In *Meskeil v C. I. E* [1973] IR 121, at 134, Walsh J stated:

*“A right guaranteed by the Constitution or granted by the Constitution can be protected by action enforced by action even though such action may not fit into any of the ordinary forms of action in either common law or equity and that the constitutional right carries with it its own right to a remedy or for the enforcement of it.”*

<sup>699</sup> (2006) 13 NWLR (Pt. 996) 127.

*not by government agencies but by ordinary individuals, ... such victims have rights against the individual perpetrators of the acts as they would have done against state actions. It follows therefore that in the absence of clear positive prohibition which precludes an individual to assert a violation or invasion of his fundamental right against another individual, a victim of such invasion can also maintain a similar action in a court of law against another individual for his act that had occasioned wrong or damage to him or his property in the same way as an action he could maintain against the State for a similar infraction.*”<sup>700</sup>

Similarly the Federal High Court, Benin Judicial Division, in *Gbemre v Shell Petroleum Development Nigeria Ltd & Ors*<sup>701</sup> examined the fundamental rights of private people against a corporate body for violation of the right to a healthy environment arising from flaring of gas. The court held the actions of the defendants in continuing gas flaring in the course of oil extraction and production violated the plaintiff’s right to life and a healthy environment.

### *Nigeria: The Way Forward*

The comparative law series carried out in this Chapter reveals a clear movement towards the embrace of strict liability for products defects. These are compelling reasons why Nigeria should take the same course. In the context of medical products, the case for doing so seems unarguable. Many medical products used by patients in Nigerian hospitals are manufactured in countries in Europe or North America where a strict product liability regime applies. Under the old (and largely

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<sup>700</sup> *Abdulhamid v Akar & Anor* (2006) 13 NWLR (Pt. 996) 127.

<sup>701</sup> (2005) AHRLR 151.

discredited) rule in *Phillips v Eyre*<sup>702</sup>, where a tort is committed abroad it is necessary for a plaintiff to establish, not merely that the defendants' conduct violated the *lex fori* but also that it was not justifiable in the place of commission. If the place of commission were to be deemed to be the country of manufacture rather than that of injury, a Nigerian plaintiff could find himself or herself in the invidious position that the claim could not proceed on the basis of strict liability (the regime applying in the place of manufacture) as it would be defeated by the rule in *Phillips v Eyre*<sup>703</sup>, since it would not be "actionable" in Nigeria. Conversely, if the place of commission of the tort were deemed to be Nigeria, the action would have to proceed in negligence, under Nigerian law, rather than strict liability. There is a very strong argument that Nigerian rules of private international law should be reformed so as to improve the position of the patient or other consumer, as has been done in the European Union with the promulgation of the Rome II Regulation on the law applicable to non-contractual obligations<sup>704</sup>. The simplest and most immediate solution, however, is for the Nigerian law of torts to embrace the strict liability regime for defective products.

If such a strict liability regime is to be enacted, how broad should the range of prospective defendants be? Clearly manufacturers, including designers and manufacturers of composite products, should be included. The European measure does not extend liability to retailers generally.

In the context of Nigeria, there is a strong argument that strict liability for medical products should extend, not only to retailers, but also to hospital authorities that prescribe a course of medication. The present system in Nigeria whereby patients

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<sup>702</sup> (1870) 6 QB 1, 28-29. It appears that the rule in *Phillips v Eyre* continues to apply in Nigeria: see Zainab Abubakar Abdulsalam, *An Appraisal of the Ascertainment of Applicable Law of Torts in Conflicts of Laws* (LLM Dissertation, Ahmadu Bello University, Zaria, Nigeria, September 2014), pp 79-83; *Benson v Ashiru* [1967] NMLR 363; *Ubanwa v Afocha and University of Nigeria* (1974) 4 ECSR 308.

<sup>703</sup> *Ibid.*

<sup>704</sup> Regulation (EC) No. 864/2007.

are sent by hospitals to buy their own medical products is certainly not fair to the patients: a more just rule would be for the hospitals to assume strict liability for defective products thus acquired by patients, with an entitlement on the part of the hospitals to seek contribution or indemnity from the manufacturers of these products.

## **Chapter Eleven**

### **Contributory Negligence of the Patient**

## *Introduction*

It is possible that a patient who has been the victim of negligent healthcare may not be entitled to full compensation for the injury suffered on account of his or her contributory negligence in failing to have taken proper care of himself or herself.

Courts have found the defence of contributory negligence to be available in medical negligence litigation in a wide range of circumstances.<sup>705</sup>

Before I examine a number of specific contexts in which the issue of contributory negligence has arisen in litigation, it may be useful to refer to the broader sociological dimension. There may be reasons why a patient in Nigeria fails to comply with the treatment regime prescribed by the doctor which do not necessarily indicate contributory negligence on the patient's part:

*“[P]oor socioeconomic status ..., low level of education, unemployment, lack of effective social support networks, unstable living conditions, long distance from treatment centre, high cost of transport, cultural and lay beliefs about illness and treatment, and forgetfulness.”*<sup>706</sup>

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<sup>705</sup> See Binchy & Komolafe, *Patients, Contributory Negligence and Medical Negligence Litigation* (2011) 4(2) Quarterly Review of Tort Law 21, from which some portions of this chapter are derived; Ben Twinomugisha, *Fundamentals of Health Law in Uganda* (Pretoria University Law Press, 2015), at 189; Olokooba & Ismail, *The Professional's Duty of Care: A Diagnostic Appraisal of the Medical Practitioner's Liability of Negligence in Tort* (2010) 3 Confluence J of Jurisprudence & Int'l L 108, at 113; Michael Hudson, *Defenses to Malpractice: What Every Emergency Physician Should Know* (2011) 41 J of Emergency Med 598, at 603-606.

<sup>706</sup> Osamor & Owumi, *Factors Associated with Treatment Compliance in Hypertension in Southwest Nigeria* (2011) 29 J of Health, Population & Nutrition 619, at 620. See also Charurat, Oyegule, Benjamin, Habib, Eze, Ele, Ibanga, Ajayi, Eng, Mondal, Gebi, Etiebet, Abimiku, Dakum, Farley & Blattner, *Patient Retention and Adherence to Antiretrovirals in a Large Antiretroviral Therapy Program in Nigeria: A Longitudinal Analysis for Risk Factors* (2010) 5 PLOS ONE 1; Ibrahim, Hadejia, Nguku, Dankoli, Waziri, Akhimien, Ogiri, Oyemakinde, Dalhatu, Nwanyawu & Nsubuga, *Factors Associated with Interruption of Treatment Among Pulmonary Tuberculosis Patients in Plateau State, Nigeria. 2011* (2014) 17 Pan Afr Med J 78; Fadare, Olamoyegun & Gbadegesin, *Medication Adherence and Direct Treatment Cost Among Diabetes Patients Attending a Tertiary Healthcare Facility in Ogbomosho, Nigeria* (2015) 27 Malawi Med J 65; Senanu Okuboyejo, *Non-Adherence to Medication in Outpatient Settings in Nigeria: The effect of Employment Status* (2014) 6 Global J of Health Sci 37; Adisa & Fakeye, *Treatment Non-Adherence Among Patients with Poorly Controlled Type 2 Diabetes in Ambulatory Care Settings in*

Courts in Nigeria should be very sensitive to this discussion and not make a finding of contributory negligence too readily.

### 1. *Failure by the Patient to Disclose Pertinent Information*

It is obvious that doctors depend to a considerable degree on patients to give them a good medical history and a clear account of their symptoms. If the patient cannot, or does not, do this, the doctor's conduct, based on insufficient or misleading information, simply may not fall below the professional standard of care.<sup>707</sup>

In determining the issue of contributory negligence, courts have acknowledged the need to have regard to the patient's particular circumstances. Patients do not choose to be ill. They generally find themselves in such a condition as a result of circumstances not of their making. To require that a patient with learning difficulties, for example, should act according to more demanding standards than those of which he or she is capable would be so obviously unjust.

In the Kenyan case of *Jimmy Paul Semenye v Aga Khan Health Services*,<sup>708</sup> where a baby boy suffered Erbs palsy or brachial injury under the care of the defendants, the defendants alleged that the mother had withheld vital information arising from complications she had had in previous deliveries. During the trial, records of the defendant were produced which showed that the mother had in fact disclosed two

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*Southwestern Nigeria* (2014) 14 Afr Health Sci 1; Atulomah, Florence & Oluwatosin, *Treatment Adherence and Risk of Non-compliance Among Hypertensive at a Teaching Hospital in Ogun State, Southwest Nigeria* (2010) 3 Acta SATECH 143; Bello, *Tortious Liability of Medical Practitioners in Nigeria: An Appraisal* (LLM Dissertation, Faculty of Law, Ahmadu Bello University, 2000), p 90.

<sup>707</sup> In *Harmse No obo Jacobus v MEC for Health: Gauteng Province* [2010] ZAGPJHC 110, at para 31, the South Gauteng High Court, Johannesburg found the defendant's conduct fell below the professional standard for his failure to heed the plaintiff's previous medical history or to notice the surgical scars on the plaintiff's right femoral leg. Mathopo J stated: "[T]he fact that the doctors were unaware of the [plaintiff's] previous history and surgical scars is indicative of their failure to properly and physically examine him. In my view members of the society expects that once they are admitted at the hospital the doctors would treat them with the necessary skill and care that is required of a reasonable practitioner."

<sup>708</sup> [2006] eKLR.

earlier miscarriages<sup>709</sup>. The Kenya High Court imposed liability and made no finding of contributory negligence against the mother, Ang'awa J stated:

*“I find no contributory negligence against the [mother] who provided all the relevant information ... If the defendants [had been] computerized they would have reconfirmed that the [mother] was their patient in one of the earlier pregnancy and would have been more diligent.”<sup>710</sup>*

## *2. Failure to Comply With Medical Instructions*

A patient sometimes fails to comply with the instructions given him or her by the doctor and other health professionals. When told to take a course of antibiotics until the tablets are all gone, some patients, feeling better after a couple of days, stop taking the tablets prematurely. Other patients fail to keep appointments or to advise doctors of a deterioration in their health. Still other patients fail to adhere to lifestyle prescriptions designed to protect them from the risk of heart attack or stroke, for example.

All of these types of case can involve a finding of contributory negligence against the patient but, in many instances, doctors will find that, in pointing the finger at the patient, they may excite the attention of the court to the prior question of whether they communicated clear instructions to the patient. It is well established that patients find it difficult to absorb complex information, especially where conveyed orally. Moreover, many patients find it very hard to understand directions as to when to take medicines and the amounts to be taken at particular times. This

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<sup>709</sup> *Ibid.*, at para 40.

<sup>710</sup> *Ibid.*, at para 83.



factor, of limited education, poor literacy and poor communication by doctors to patient, is a major feature of healthcare in Nigeria.

In *Premier of the Province of KwaZulu-Natal v Sonny*,<sup>711</sup> the Supreme Court of Appeal of South Africa considered the imperative instructions given by medical staff to the patient, and absolved her of contributory negligence<sup>712</sup>.

Where children are patients, they are inevitably dependent on their parents (or other carers) to look after their healthcare. In *Kgosiemang v MEC for the Department of Health, North-West Province*,<sup>713</sup> where a nine-year old plaintiff claimed damages for negligent treatment at a hospital, the defence of contributory negligence was made, based on her alleged failure to return to the hospital or go to an ophthalmology clinic and her alleged failure to heed the instructions on the medication she was taking. Landman J rejected this evidence. Referring to the plaintiff's age, Landman J observed that she would have been "entirely dependent on her mother for guidance and the means to seek medical attention and as regards the intake of medicine and application of ointment"<sup>714</sup>.

### 3. *Failure to Undergo Necessary Medical Treatment*

The courts have held that, if a plaintiff who has been injured declines to undergo necessary medical treatment in circumstances where that refusal is unreasonable having regard to the nature of the treatment, damages should be computed on the basis that the treatment was carried out.

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<sup>711</sup> [2011] ZASCA 6.

<sup>712</sup> *Ibid.*, at para 34, Navsa JA stated: "Insofar as contributory negligence is concerned, none can be attributed to [the plaintiff]. As could be expected she followed instructions, including the directive that she return to the clinic. ... The doctor did not tell [the plaintiff] why the second ultrasound scan was required. ... The failure to do so, coupled with the clinic's reassurance that there was nothing untoward in the ultrasound report and the nurse's statement that a second scan is only required near the end of one's pregnancy understandably lulled [the plaintiff] into a false sense of security."

<sup>713</sup> [2013] ZANWHC 14.

<sup>714</sup> *Kgosiemang v MEC for the Department of Health, North-West Province* [2013] ZANWHC 14, at para 220.

In the context of Nigeria, it is respectfully submitted that courts should be particularly reluctant to stigmatise as contributory negligence the failure of a patient to agree to subject himself or herself to a proposed treatment that the doctor thinks is obviously desirable. Patients in Nigeria are often affected by cultural influences that are very strong within their world but are regarded with contempt by doctors, who have cosmopolitan values. It would be quite unjust if compensation were to be reduced. This would be to penalise the patient for being affected by these cultural influences.

#### 4. *Dangerous Lifestyle Choices*

What is the position where the patient is a person who has engaged in dangerous lifestyle choices – with alcohol, other drugs, whether legal or illegal, for example, or by overindulgence in food or underindulgence in exercise? The courts have given varying answers. Broadly speaking, it is not open to a doctor to argue that, because the patient who came to see him or her was, for example, a person who had abused alcohol or drugs, that some reduction in compensation should on that account alone be made. This is not to say that the court should ignore that dimension. The effect of patient's lifestyle choices may impact on issues of causation or damages, for example. So, a doctor who operated negligently on a patient's liver is perfectly entitled to point to the ravages already inflicted on the liver by the patient's overindulgence in alcohol to the extent that this element may affect the court's determination of the issues of causation and damages, but not contributory negligence. If the same patient persisted in drinking excessively *after* the operation, contrary to clear medical advice, the court would rightly reduce compensation to take account of that contributory negligence (as well as factoring this conduct into the issues of causation and quantum of damages).

In a number of English decisions<sup>715</sup>, courts have reduced the compensation awarded to patients on account of their contributory negligence in smoking.

The position in Nigeria regarding smoking is somewhat complex. Nigeria "has one of the lowest smoking prevalence rates in the world".<sup>716</sup> Only 10% of the population smokes.<sup>717</sup> Consumption among females is estimated at 1%.<sup>718</sup> The National Tobacco Act 2015 banned smoking in a range of public spaces. The legislation was designed to give domestic effect to the World Health Organisation Framework Convention on Tobacco Control. Enforcement remains a challenge.

Would it be wise for Nigerian courts to adopt the same approach to contributory negligence in regard to smoking as that of their English counterparts? In favour of their doing so, it may be argued that the dangers of smoking have been well established for several decades and are fully appreciated, even among the more disadvantaged members of society.<sup>719</sup> Perhaps the best approach would be for Nigerian courts to be willing in principle to make a finding of contributory negligence but also to be fully sensitive to the problems of illiteracy and poor educational opportunities before reducing compensation in this context.

### *Carelessness of a Hospital Patient as to Safety of a Child in Patient's Custody*

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<sup>715</sup> Notably *Badger v Ministry of Defence* [2006] 3 All ER 173, [2005] EWHC 2941 (QB); *Horseley v Cascade Insulation Services Ltd* [2007] EWHC 2945, *Shortell v Bical Construction Ltd* (16 May 2008), English HC, Mackay J.

<sup>716</sup> Centre for Public Policy Alternatives, *A Premier on Tobacco Consumption and Regulation in Nigeria* (22 August 2015), <https://cparesearch.org/a-premier-on-tobacco-consumption-and-regulation-in-nigeria/>

<sup>717</sup> *Ibid.*

<sup>718</sup> *Ibid.* See also Awopaju, Erhabor, Awosusi, Awopaju, Adewole & Irabor, *Smoking Prevalence and Attitudes Regarding Its Control Among Health Professional Students in South-Western Nigeria* (2013) 3 Ann. Med Health Sci Res 355; Odukoya, Dada, Olubodun, Igwilo & Ayo-Yusuf, *Risk Perception and Correlates of Tobacco Use among Young People Outside of Formal School Settings in Lagos State, Nigeria* (2016) 17 Asian Pac J Cancer Prev 2833, 2833; Odukoya, Odeyemi, Oyeyemi & Upadhyay, *Determinants of Smoking Initiation and Susceptibility to Future Smoking among School-Going Adolescents in Lagos State, Nigeria* (2013) 14 Asian Pac J Cancer Prev 1747, at 1748.

<sup>719</sup> As is apparent in the findings of Odukoya, Dada, Olubodun, Igwilo, & Ayo-Yusuf, *Risk Perceptions and Correlates of Tobacco Use among Young People Outside Formal School Settings in Lagos State, Nigeria* (2016) 17 Asian Pac J Cancer Prev 2833.

In *Martin v Malamulo Hospital*,<sup>720</sup> the Malawi High Court had to consider the issue of the carelessness of a patient, not towards *his or her own health or welfare, but rather in respect of a child in the patient's custody* while the patient was at hospital. The plaintiff delivered a baby through caesarean operation at the defendant's hospital. The hospital detained both mother and the child in the ward on account of outstanding bills to be settled. The child went missing when the mother was sleeping. The mother sued the hospital for negligence in its care and supervision of the infant. The claim was rejected on the basis that the infant's disappearance was not reasonably foreseeable<sup>721</sup>, and more fundamentally, that the mother was to blame for oversleeping. Chipeta J concluded:

*“When this act of theft by a third party is coupled with the fact that the plaintiff herself, by over sleeping, did nothing to protect her child, I do not think I would in the least be justified in avoiding the truth and heaping blame on the defendant. As I see it therefore even if the plaintiff had proved existence of duty of care and breach, which she has not, I would have found the damage herein too remote from the breach.”*<sup>722</sup>

This holding is surely unfair to the mother. Her presence in the hospital was in the first place probably the result of the tort of false imprisonment by the hospital as it

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<sup>720</sup> [2005] MLR 235.

<sup>721</sup> *Martin v Malamulo* [2005] MLR 235, Chipeta J (at 246) stated: “I accordingly very sincerely doubt that, beyond what the hospital already did, it had any further duty to ensure that this child was safe. It is after all also in evidence that this is the first case of its kind, of a child going missing, that has occurred at Malamulo Hospital. I really cannot therefore say that in the circumstances it must have been reasonably foreseeable on the part of the defendant, that if it left the child with her mother on a bed in the maternity ward and did not pay this child any extra attention, then chances were that it would go missing. I thus do not think that the plaintiff has made out the existence of the requisite legal duty in respect of the tort she has based her suit on.”

<sup>722</sup> *Ibid.*, at 248.

is unlawful to imprison someone to enforce a civil debt.<sup>723</sup> Secondly, the hospital clearly owed a duty of care to ensure that the infant would not be stolen (by a member of staff or an outsider coming into the hospital).<sup>724</sup> Thirdly, for a woman to sleep a great deal after giving birth does not involve any carelessness on her part but rather is an aspect of her medical condition.

### *Nigeria: The Way Forward*

Finally in this Chapter, I consider the best way forward for Nigerian law to develop in regard to the contributory negligence of patients. The law in this area appears fair and sensible in its conceptual formulation: it seems only just that there should be some reduction in the compensation awarded to a patient who is the victim of medical negligence in cases where the patient has been culpable in taking care of his or her own welfare.

The challenge for the court is to apply this principle in a way that is sensible to the circumstances of the particular patient – his or her level of education and literacy, cultural background, age, and mental development, for example. These factors can act in combination to reduce a patient's cognitive appreciation of the risks he or she faces if he or she fails to adhere to a particular treatment regime. Thus, a fairly recent study of compliance practices in Nigeria in regard to hypertension found that patient's perception of seriousness varied widely and that:

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<sup>723</sup> *Sunbolf v Alford* (1838) 3 M & W 248; 150 ER 1135; *Perry v Fried* (1972) 32 DLR (3d) 589.

<sup>724</sup> See, eg, *Ndola Central Hospital Board of Management v Kaluba & Anor* [1997] ZMSC 23, where the Supreme Court of Zambia upheld a verdict of negligence against the hospital in respect of its negligent failure to protect a newborn infant from being stolen. The phenomenon of theft of babies from African hospitals is notorious. A recent instance in Nigeria occurred at the General Hospital, Dutse, in March 2016: see Premium Times (7 April 2016), "Nigeria: Stolen baby – Jigawa Steps Up Security in Hospitals". See further Timothy Opaluwa, *Child Theft in Hospitals: Which Way Out?* (Leadership, 11 June 2016). In accord are the Ghanaian decision of *Asafo v Catholic Hospital of Apam* [1973] 1 GLR 282 and the Kenyan decision of *Muchoki v Attorney-General* [2004] 2 EA 178. These decisions are considered further in the section of the Chapter 13 on Proof of Negligence dealing with *res ipsa loquitur*.

*“[t]his perception must be viewed in the context of the knowledge of the condition that the individual has and how significantly his educational attainment, culturally set values and beliefs impinge on this knowledge. These modifying factors also awaken or subdue threat of the likelihood of serious consequences as a result of inactivity.”<sup>725</sup>*

One should also be conscious of the serious lack of financial resources suffered by very many patients. After the first dose of medicine provided by the hospital, patients often find themselves unable to pay for any further dose. There is no governmental support or subsidy for patients in this position. Poverty should never be stigmatised as contributory negligence.

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<sup>725</sup> Atulomah, Florence & Oluwatosin, *Treatment Adherence and Risk of non-compliance among hypertensives at a teaching Hospital in Ogun State, Southwest Nigeria* (2010) 3(2) Acta SATECH 143, at 147.

## Chapter Twelve

### Causation

#### *Introduction*

In this Chapter, I examine the law relating to causation. Causation is a formidable hurdle for plaintiffs in medical negligence litigation as there are great uncertainties in the medical world regarding the causes of many adverse conditions. In the Nigerian context, injured patients find it very difficult to obtain expert witnesses. If the doctor or hospital can raise questions as to causation, the patient often is in no position effectively to challenge them.

Let us go back to basic principles. In negligence litigation, the plaintiff must establish, not merely that the defendant owed and breached a duty of care to the plaintiff, but also that such breach caused, materially contributed to, or increased the risk of, the injury of which the plaintiff complains.<sup>726</sup> Thus, in that broad sense

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<sup>726</sup> *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428, the court examined whether the plaintiff's death was a result of the negligence of the defendant. The court held that the plaintiff has failed to establish, on the balance of probabilities, that the defendants' negligence caused the death of the deceased. Nield J stated: "... the defendants' casualty officer was negligent in failing to see and examine the deceased, and that, had he done so, his duty would have been to admit the deceased to the ward and to have him or caused him to be treated."

a causal connection must be established between the tortious act of the defendant and damage which the plaintiff suffers.<sup>727</sup>

The causal requirement of factual causation is generally determined by reference to a conventional "but for" test principle.<sup>728</sup> If the injuries that the plaintiff sustained would not have occurred but for the defendant's tortious act, the causal requirement will be fulfilled.

A classic example in the context of medical negligence action was the case of *Barnett v Chelsea and Kensington Hospital*.<sup>729</sup> The plaintiff was the widow of a man who died of arsenic poisoning from contaminated sandwiches after he had attended the defendant hospital and negligently been sent home without treatment. The deceased was a night watch-man working over New Year's Eve. The nurse on duty informed the casualty officer of the man's condition, but the casualty officer, who suspected that the man had simply overindulged on New Year's Eve, instructed the nurse to inform the plaintiff to return home and come back on another occasion. The man was admitted to hospital later that morning, after considerable delay but died some time later. The question examined by the court was whether had deceased would have died had the defendant acted without negligence and admitted him earlier. The court was of the opinion on the basis of

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<sup>727</sup> McMahon & Binchy, *Law of Torts* (4<sup>th</sup> ed, Bloomsbury Professional Ltd, 2013), at para 2.03, state: "First there is the problem of causation. It is said that the defendant cannot be liable to the plaintiff unless he has caused the damage in question. This means at the outset that the act of the defendant must be linked in a factual or scientific way to the injury of the plaintiff if the defendant is to be considered as being potentially liable. This involves a factual investigation. If there is no connection between the defendant's conduct and the plaintiff's injury then the defendant cannot be liable to the plaintiff. But just because the defendant caused in a *factual sense* the plaintiff's injury does not necessarily mean that he will be *liable in law* to the plaintiff. Before the courts will hold the defendant liable in law they must also be satisfied on policy grounds, that the defendant *legally caused* the damage to the plaintiff. ..." It should be noted that a causal connection may be insufficient in certain situations to impose liability, particularly if there is a new intervening act between the defendant's tortious act and damage.

<sup>728</sup> In *Cork v Kirby Maclean Ltd* [1952] 2 All ER 402 (CA), the Court of Appeal approached the question of causal requirement. Denning LJ (at 407) stated: "Subject to the question of remoteness, causation is I think, a question of fact. If you can say that the damage would not have happened but for a particular fault, then that fault is in fact a cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not a cause of the damage. It often happens that each of the parties at fault can truly say to the other: 'But for your fault, it would not have happened.' In such a case both faults are in fact causes of the damage."

<sup>729</sup> [1969] 1 QB 428.



evidence that, even if the defendant had acted with due care and admitted the deceased<sup>730</sup>, he would still have died of arsenic poisoning as the poison had already irretrievably and fatally taken its hold. Nield J, in deciding causation, stated:

*“But that, since he must have died of the poisoning even if he had been admitted to the wards five hours before his death and treated with all care, the plaintiff had failed to establish on the balance of probabilities that the defendants’ negligence had caused the death.”*<sup>731</sup>

Thus, the defendant’s conduct was not the cause of the death of the deceased.

In a later development, courts in many jurisdictions took a policy decision to modify their approach to causation in cases where the conventional application of the “but for” test would seem to have a particularly unjust outcome. These courts were willing to impose liability where the defendant’s negligence constituted: (1) a *material contribution to the plaintiff’s injury*<sup>732</sup>, or (2) a *material increase in the risk of such an injury occurrence*<sup>733</sup>.

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<sup>730</sup> *Ibid.*, the Court found the defendants liable for breach of duty of care. Nield J (at 434), stated: “[T]he defendants’ casualty officer was negligent in failing to see and examine the deceased, and that, had he done so, his duty would have been to admit the deceased to the ward and to have treated him or caused him to be treated.”

<sup>731</sup> *Barnet v Chelsea and Kensington Hospital* [1969] 1 QB 428, at 429.

<sup>732</sup> *Wardlaw v Bonnington Castings Ltd* [1956] AC 613.

<sup>733</sup> *McGhee v National Coal Board* [1973] 1 WLR 1. One should also note the developing jurisprudence on the loss of a chance by the plaintiff to avoid a deleterious outcome of medical treatment. Clearly, if the negligent treatment prevented the plaintiff from avoiding a deleterious outcome that was more likely than not to have been avoided if the treatment had been carried out with due care, compensation for that loss of chance should be forthcoming. Thus, in the recent decision of the Constitutional Court of South Africa in *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33, liability was imposed where the failure to provide appropriate emergency treatment to a boy who had injured his spine in a rugby match deprived him of the chance of benefiting from the procedure that had a 64% chance of success. In cases where the chance is less than 50%, matters are more controversial. *Philp v Ryan* [2004] 4 IR 241, the Supreme Court of Ireland examined the negligent failure of the defendant who failed to diagnose prostate cancer before a correct diagnosis and treatment was provided after eight months delay. Fennelly J, stated (at 249): “[I]t seems to me to be contrary to instinct and logic that a plaintiff should not be entitled to be compensated for the fact that, due to the negligent diagnosis of the medical condition, he has been deprived of appropriate medical advice and the consequent opportunity to avail of treatment which improve his condition. I can identify no contrary principle of law or justice. It is commonplace that allowance is made in

These approaches have generally been in response to situations where the plaintiff has found it impossible in the light of the existing state of scientific and medical knowledge, to establish the cause of his or her injury.

The British courts have been in the vanguard of developing modifications to the "but for" test. To date, there has been little or no response in the Nigerian jurisprudence to the developments. The focus for the developments has been employer's liability. Although the House of Lords did not expressly restrict the modifications to litigation against employers, somewhat different policy issues arise in the context of medical negligence litigation.

The Supreme Court of Ireland looked with favour on the English decision of *Wilsher v Essex Area Health Authority*<sup>734</sup> in a case decided on "but for" test principle in *Quinn (minor) v Mid Western Health Board & Anor.*<sup>735</sup>

The House of Lords in *Fairchild v Glenhaven Funeral Services Ltd*<sup>736</sup> modified the traditional "but for" test of causal connection further than had been done in *Wardlaw* and *McGhee*. In adopting its new approach, their Lordships placed great emphasis on considerations of fairness and reasonableness and on policy.

In *Fairchild*, the plaintiff had worked at different times under different employers and, during the course of his employment with them, had inhaled substantial quantities of asbestos dust containing asbestos fibre which caused him to suffer

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awards and in settlements for the *risk* that an injured plaintiff *may* in the future develop arthritis in an injured joint. The risk may be high or low – a 15% risk is often mentioned – but damages are paid. I cannot agree that this is any different from what is sought in the present case. It does not matter that the damage suffered by the plaintiff consists of the loss of an opportunity to avail of treatment. It might, with equal logic, be described as an increased risk of shorter life expectancy. It seems to me as illogical to award damages for a probable future injury as if it were a certainty, as to withhold them where the risk is low on the basis that it will not happen at all." Contrast the contrary approaches where the House of Lords refused to impose liability in the context of medical negligence in *Hotson v East Berkshire Area Health Authority* [1987] AC 750; *Gregg v Scott* [2005] 2 WLR 268, and *Quinn (minor) v Mid Western Health Board & Anor* [2005] 4 IR 1.

<sup>734</sup> [1988] 1 AC 1074.

<sup>735</sup> [2005] 4 IR 1.

<sup>736</sup> [2003] AC 32.

mesothelioma, a fatal disease. He was unable to prove on the balance of probabilities that his injury resulted during his employment with any one employer. There was no dispute but that all the employers had been negligent in exposing him to the asbestos dust; but the defendant contended that the plaintiff had not established by evidence that it had been *its* breach of duty that was a cause of the injury.

In finding liability against the defendants, the House of Lords considered the approach of the Supreme Court of California in the famous hunting expedition case of *Summers v Tice*<sup>737</sup>. There, each of two defendants at or about the same time had shot at a quail and in doing so fired negligently in the direction of the plaintiff, who was struck by shot from one of the defendants. The Supreme Court of California held that both were jointly and severally liable<sup>738</sup> even though it could not be identified which of them had actually injured the plaintiff<sup>739</sup>. The House of Lords, on the basis that medical science could not establish on a balance of probabilities the source of the fibre or fibres which caused the plaintiff's mesothelioma, based its decision on policy considerations<sup>740</sup> similar to those which the courts have been

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<sup>737</sup> (1948) 33 Cal.2d 80.

<sup>738</sup> Cf the *obiter* of Kearns J of the Supreme Court of Ireland in *Quinn (minor) v Mid Western Health Board & Anor* [2005] 4 IR 1, on the liability of concurrent wrongdoers.

<sup>739</sup> *Summers v Tice* (1948) 33 Cal.2d 80, at paras 6 and 10, Carter J, stated: "When we consider the relative position of the parties and the results that would flow if plaintiff was required to pin the injury on one of the defendants only, a requirement that the burden of proof on that subject be shifted to defendants becomes manifest. They are both wrongdoers – both negligent toward plaintiff. They brought about a situation where the negligence of one of them injured the plaintiff, hence it should rest within them each to absolve himself if he can. ... We have seen that for the reasons of policy discussed herein, the case is based upon the legal proposition that, under the circumstances here presented, each defendant is liable for the whole damage whether they are deemed to be acting in concert or independently."

<sup>740</sup> Symmons C. R., *The Duty of Care In Negligence: Recently Expressed Policy Elements – Part 1* (1971) 34 *The Modern Law Review* 394, at 394, remarks: "In retrospect, until recently as the 1960s, it might be said without controversy that Lord Atkin's 'neighbour' test in *Donoghue v Stevenson* [1932] AC 562, based as it is on reasonable foreseeability, has been used by the courts of this country as a convenient façade behind which they could extend, or restrict extension of, the existing categories of negligence, which, as we have been judicially reminded, 'are never closed'. Consequently, in creating 'notional' duties of care in novel 'situation-patterns' in the past, the courts have been accused of concealing the true judicial process by their reticence in articulating underlying policy considerations and their almost inevitable resort to the vague and facile test of reasonable foreseeability to determine this highly important issue. Within the last ten years, however, almost dramatically, English courts seem to have

applying over the years to extend or restrict the duty of care.<sup>741</sup> Lord Bingham identified:

*“... a strong policy argument in favour of compensating those who have suffered grave harm, at the expense of their employers who owed them a duty to protect them against that very harm and failed to do so, when the harm can only have been caused by breach of that duty and when science does not permit the victim accurately to attribute, as between several employers, the precise responsibility for the harm he has suffered. I am of opinion that such injustice as may be involved in imposing liability on a duty-breaking employer in these circumstances is heavily outweighed by the injustice of denying redress to a victim.”*<sup>742</sup>

Lord Bingham’s conclusion was premised on the circumstances of the case which required the Court, in finding for the plaintiff on justice and policy considerations, to impose liability.<sup>743</sup> This policy approach has attracted criticism among

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taken the cue from their Commonwealth counterparts and begun openly to analyse and discuss policy elements in such cases.”

<sup>741</sup> In *Dorset Yacht Co Ltd v Home Office* [1969] 2 All ER 564, at 567, Lord Denning stated: “It is, I think, at bottom a matter of public policy which we, as judges, must resolve. This task of ‘duty’ or ‘no duty’ is simply a way of limiting the range of liability for negligence.”

<sup>742</sup> *Fairchild v Glenhaven Funeral Services Ltd* [2003] AC 32, at para 33.

<sup>743</sup> In *Lee v Minister of Correctional Services* [2012] ZACC 30, the case concerned whether the plaintiff’s detention and the defendant’s failure to take prevent measures by the defendant caused the plaintiff to be infected with tuberculosis (TB) while in detention. The Constitutional Court of South Africa examined the question whether the causation aspect of the common law test for delictual liability was established and, if not, whether the common law needs to be developed to prevent an unjust outcome. Nkabinde J (at para 74) stated: “The concern that a flexible approach to factual causation and the relaxation of the but-for test in appropriate cases may lead to limitless liability, especially in relation to omission cases, has been addressed by the development of the test of reasonableness in the wrongfulness enquiry. That enquiry now concerns the reasonableness of imposing liability on a defendant, and is not restricted to the reasonableness of the defendant’s conduct, which is an element of the separate negligence enquiry in our law. The wrongfulness requirement in our law thus provides a normative mechanism, in addition to the negligence enquiry, to decide whether delictual liability should be extended or restricted. On my understanding of the duty of care in other common law systems, it does not allow for that kind of extended judicial policy control of

commentators, who argue that the Court failed to identify the policies which it considered to be at stake and that mere reference to fairness and reasonableness was insufficient justification for departing from the traditional rules regarding causation.<sup>744</sup>

Courts, in recent times have generally been more willing to extend the test of a material contribution to injury outside the context of employers' liability to medical negligence actions where a plaintiff has difficulty of proving causation but he or she proves that the material contribution of the defendant's negligence is significant and it was more than negligible.<sup>745</sup> In *Bailey v Ministry of Defence & Anor*,<sup>746</sup> the plaintiff had earlier been admitted in the first defendant's hospital with diagnosis of gallstones. At the first defendant's hospital, the plaintiff bled extensively during the procedure of Endoscopic Retrograde Cholangiopancreatography (ERCP) to remove the gallstones from her bile duct. As a result, she became weak and developed pancreatitis, a post-ERCP reaction. At this stage, she was transferred to the second defendant's hospital and admitted to the renal ward where she made a considerable progress before her condition deteriorated, she vomited and aspirated her vomit

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imposing liability in tort, hence the perceived need to do so through exceptional relaxation of the but-for test of causation.”

<sup>744</sup> See generally Jonathan Morgan, *Lost Causes in the House of Lords: Fairchild v Glenhaven Funeral Services Ltd* (2003) 66 *The Modern Law Review* 277, at 279, argues: “While these are noble sentiments, they should not be dignified with the label of policy. Such a ‘policy’ says nothing more than that ‘injured claimants should recover’, and therefore it is much too wide to be of any use in setting the boundaries of what, after all, is said to be an exceptional approach. ... A convincing justification must explain why recovery is allowed in certain cases, and in those cases only.”

<sup>745</sup> In *F v Chan Tanny* [2003] 4 SLR (R) 231; [2003] SGHC 192, the plaintiff alleged that the defendant failed to consider properly the various signs of foetal distress at various stages of pregnancy with the result that she did not timeously intervene by a caesarean section which, if done in time, would have prevented [child] from being inflicted with the neurological defects. The Singapore High Court examined two issues on causation: first, whether the defendant on a balance of probabilities breach any duty of care, secondly, if there was, whether it, singly or in any combination, caused or materially contributed to the injury which the plaintiff suffered. The Court by reference to the principle in *Wardlaw v Bonnington Castings Ltd* [1956] AC 613, found that the defendant had not breached the duty of care owed to the plaintiff. In *Boustead v North West Strategic Health Authority* [2008] EWHC 2375 (QB), the Court applied the principle in *Wardlaw* case and held that the plaintiff had satisfied the burden of proof that the breach of duty made a material contribution to injury.

<sup>746</sup> [2009] 1 WLR 1052.

leading to a cardiac arrest that caused her to suffer hypoxic brain damage. The issue in the case concerned causation, what caused the plaintiff to aspirate her vomit. In determining liability, the Court of Appeal examined two issues: first, the plaintiff's weakness arising from pancreatitis (post-ERCP), which is considered a non-negligent cause, and secondly, the plaintiff's inability to prevent her aspiration which resulted to a cardiac arrest that caused her to suffer hypoxic brain damage, which is considered a negligent cause. In reaching a conclusion, the Court affirmed the findings of the trial court that there were two contributory causes of that weakness (the non-negligent cause and the negligent cause), that each of the components had contributed materially to the overall weakness and it was the overall weakness that caused the aspiration. Waller LJ stated:

*“If all that is necessary is 'a material contribution' and if, for that material contribution to be established, it is sufficient to establish a contribution which is more than **negligible** then it seems to me that the judge's conclusion cannot be faulted. The question is whether that is sufficient.”*<sup>747</sup>

The Court of Appeal in reaching this decision considered a number of previous cases in the context of medical negligence which had created doubt about the application in that context of the test of a material contribution<sup>748</sup> to injury and

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<sup>747</sup> *Bailey v Ministry of Defence* [2009] 1 WLR 1052, at para 34.

<sup>748</sup> *Ibid.*, at para 44-45, Waller LJ stated: “Are there any case in the medical negligence context which cast doubt on applying *Wardlaw* in that context? Certainly in *Wilsher* the House of Lords applied strictly the 'but for' test and rejected the Court of Appeal's interpretation of *McGhee* but it was not a case of causes cumulatively causing injury but a case where there were different distinct causes which operated in a different way and might have caused the injury and where the claimant could not establish which cause either 'caused or contributed' to his injury. It was inadequacies of medical science that put the claimant in the position of not being able to establish the probability of one cause as against the other but the House of Lords were not prepared to place the case in an exceptional category. *Hotson* was a case where the House of Lords held that the cause of the injury was the non-negligent falling out of the tree and that that injury would, on the balance of probabilities, have occurred anyway without the negligent delay in

material increase in risk of injury. The Court of Appeal concluded that no distinction should be drawn between medical negligence and non-medical negligence cases<sup>749</sup> on the basis that the issue of causation in both situations is determined under the same principle irrespective of the cause or source of the injury.<sup>750</sup>

### *Causation in the Nigerian and Other African Courts*

There is a dearth of cases on causation in negligence litigation in Nigeria. Such authorities as can be found have determined the issue of causation under the conventional "but for" test.

This dearth in caselaw enables Nigeria to examine decisions from other common law jurisdictions for guidance. Whether the Nigerian courts will prove willing to embrace the development brought about by the *Wardlaw*, *McGhee* and *Fairchild* cases is not clear. The innate conservatism of the Nigerian courts would suggest that they might be opposed to these developments; however, the somewhat unreflective disposition of the Nigerian courts to quote British precedents that embrace novel approaches could mean that these cases will receive the endorsement of the Nigerian courts. Of course, the best solution would be for the

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treatment; thus the negligent conduct made no contribution to causing that injury. *Gregg v Scott* was again a medical negligence case but was not concerned with whether the negligence made a material contribution to the damage."

<sup>749</sup> *Bailey v Ministry of Defence* [2009] 1 WLR 1052, at para 46, Waller LJ stated: "In a case where medical science cannot establish the probability that 'but for' of an act of negligence the injury would not have happened but can establish that the contribution of the negligent cause was more than negligible, the 'but for' test is modified, and the claimant will succeed."

<sup>750</sup> In *Popple (A Child) v Birmingham Women's NHS Foundation Trust* [2012] EWCA Civ 1628, the plaintiff suffered brain damage during delivery which resulted to athetoid cerebral palsy under the care of the defendant. The Court of Appeal examined whether the plaintiff would have been born before the injury occurred and whether an episiotomy should have been performed to facilitate delivery at a certain time. The findings of the Court revealed that the defendant's failure to deliver the plaintiff before the time he was actually delivered materially contributed to the damage. Ward LJ stated: "[T]he negligent failure to deliver [the plaintiff] before 14.44 caused all the damage if this was a 15 minute insult. Medical science cannot establish whether it was a 15 minute insult or a 20 minute insult. If it did take 20 minutes, the damage done in the last five minutes must have made a contribution to the overall harm which was more than minimal."

Nigerian courts to make an informed choice for the future development of the law after due consideration of the policy issues raised in them.

Looking more broadly at the caselaw in other African jurisdictions, the absence of any consideration of complex causal issues in medical negligence litigation is striking. There are only a few decisions in which causation has been addressed.

In *Mtileni v Registered Trustees of Blantyre Adventist Hospital*,<sup>751</sup> the plaintiff delivered a baby girl at 24 weeks gestation with a weight of 800g at the defendant's hospital. A staff nurse, on recommendation of the attending doctor who was asked when it became necessary to administer glucose on the new born child but mistakenly administered saline solution instead, the child died few days after. The Malawi High Court in deciding negligence held the defendant liable<sup>752</sup>. On the issue of causation, the court noted that proof of causation can be established by inference where facts are such that there can be no other inference from breach of duty other than causation. However, it acknowledged as in the present case that such is difference as there were two possible causes of the child's death; first, wrong administration of saline solution and secondly, extreme prematurity of the child in question. In deciding, the Court weighed the competing evidence on the cause of the death, holding that the death was due to extreme prematurity. Potani J concluded:

*“[O]n the evidence before the court, the balance of probabilities tends to show that the death of the plaintiff's child cannot be attributed to the negligence of the defendants. It was a death that came about due*

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<sup>751</sup> [2006] MLR 309.

<sup>752</sup> *Ibid.*, at 313, Potani J stated: “Since saline solution was not part of the treatment the child required, it would follow that it was an error to administer it and in the view of the court it was such an error a reasonably skilled and careful practitioner would not have succumbed to.”



*to the inevitable risk to infection extreme premature children are prone to.*<sup>753</sup>

In *Herman Nyangala Tsuma v Kenya Hospital Association t/a The Nairobi Hospital & Ors*,<sup>754</sup> the plaintiff was diagnosed pneumonia by the second defendant at the first defendant's emergency unit after which the third defendant, a renal specialist, took over the plaintiff's care but failed to refer the patient to a chest specialist. The Kenyan High Court held that the deviation from accepted practice<sup>755</sup> had resulted in complications in the treatment of the plaintiff to be on regular medication for his life time.<sup>756</sup>

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<sup>753</sup> *Mtileni v Registered Trustees of Blantyre Adventist Hospital* [2006] MLR 309, at 316. In a Kenyan case of *Moi Teaching and Referral Hospital v Aura (Minor suing through her mother)* [2012] eKLR, the plaintiff alleged negligence that she had a cut on her left parietal region during her delivery by the defendants. The defendants denied negligence and put the plaintiff to strict proof. The High Court of Kenya distinguished both *Bolam* and *Wilsher* cases from the facts of the present case and held that the plaintiff had established negligence to found the defendants' liable. Azangalala J stated: "[T]here is no doubt as to who caused the cut on the plaintiff. It was also not the defendant's case that some other event could have caused the cut on the plaintiff."

<sup>754</sup> [2012] eKLR.

<sup>755</sup> *Herman Nyangala Tsuma v Kenya Hospital Association t/a The Nairobi Hospital & Ors* [2012] eKLR, at para 55, G. V. Odunga J stated: "[I]t is accepted that there may be variation in approaches to particular cases. It is only in cases where a doctor decides for reasons only known to himself to deviate from well known procedures that in the event that that deviation leads to injury to a patient that the court will find fault with the doctor concerned."

<sup>756</sup> Contrast *Gabriel v Government of Seychelles* [2006] SCSC 92, a decision of the Supreme Court of Seychelles, where the plaintiff developed a condition to neurinoma of the medium nerve after a series of surgical interventions following a cut injury to his left wrist. The Court held that the neurinoma was "the outcome of the plaintiff's injury and his physiological constitution" rather than to negligence in his treatment. In *Kirti R. Chudasama v Social Service League & Anor* [2004] eKLR, the plaintiff had an accident which caused her fractures of the femur and the left leg. She was admitted at defendant's hospital where she was transfused with blood O- negative on two different occasions before it could be realised on the third occasion that her blood group was O+ positive. The plaintiff underwent a series of operations to rectify the complication arising from the accident and allegedly wrong blood transfusion. The defendant argued that the plaintiff had had a pre-existing renal condition which could have affected and accelerated her new condition. The issue in the case thus was whether a patient's pre-existing condition such as renal failure and anaemia could be regarded as the cause of her ultimate injury. The High Court of Kenya adopted expert evidence which admitted that wrong transfusion accelerated renal failure and speeded up the reaction, holding the defendants liable for the plaintiff's condition. This expert evidence had actually been given by a witness called on behalf of the defendant. Makhandia Ag. J (at para 26) stated: "The evidence is consistent with the plaintiff's own evidence that her reaction to the wrong transfusion was always severe. This evidence was unchallenged and I take it that whereas the plaintiff may have had an existing renal condition, the wrong transfusion enhanced the condition to the suffering of the plaintiff."

It would seem beyond argument that the *Wardlaw* test should form part of Nigerian law. It also would seem just that a patient whose chances of recovery have been damaged by negligent medical care should have a right to compensation. I address these matters in the final chapter.

## **Chapter Thirteen**

### **Proof of Negligence in Medical Negligence Litigation**

#### *Introduction*

In this Chapter, I examine the legal requirements relating to proof of a medical negligence claim. As is the case for negligence claims generally, the burden of

proof rests on the plaintiff to prove all aspects of his or her case to the required standard of the balance of probabilities or preponderance of evidence – that a duty was owed by the defendant; that this duty was breached; and that the breach was the proximate cause of the injury or damage.

### *Direct and Circumstantial Evidence*

The plaintiff, in seeking to prove his or her case, may have recourse to both direct and circumstantial evidence. Direct evidence is a proof of fact arising from the testimony of what a witness personally saw, or heard or did establishing such a fact without inference or presumption, while circumstantial evidence<sup>757</sup> is evidence that does not expressly prove the fact asserted but generates a reasonable inference that it is so. For example, in medical negligence claims where a swab, sponge, broken needle or any surgical instrument has been left inside a patient's womb or body following surgery, this fact creates a reasonable inference that a member of the surgical team was guilty of an act of negligence in failing to have removed it. Direct and circumstantial evidence are both legitimate ways of proving a case and neither is inherently superior to the other.<sup>758</sup> Certainly, there should be no assumption that direct evidence is in some way preferable to circumstantial evidence. A clear inference can often be drawn from a simple piece of circumstantial evidence, while a cacophony of competing evidence of a direct kind can leave the judge unsure as to where the truth lies.

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<sup>757</sup> *Vogreg v Shepard Ambulance Service* (1955) 47 Wn.2d 659, at 662; 289 P.2d 350, the Supreme Court of Washington stated: "A case in which the doctrine of *res ipsa loquitur* is applicable is a circumstantial-evidence case. In it, the jury is *permitted to infer* negligence from an accident which ordinarily would not have occurred unless someone was negligent. The jury may make the inference of negligence or it may refuse to do so."

<sup>758</sup> In a criminal law context, the Alberta Court of Appeal in *R v McEwan* [1933] 1 DLR 398, stated: "... but think that there is ordinarily greater certainty in proof by direct than *circumstantial evidence*. In the case of direct evidence error may arise from mistake or untruthfulness. In the case of *circumstantial evidence* the same chances of error arise and there is the additional chance of error in fallacious inference by the Court. But whether ... right or wrong in the view that ... have expressed, no useful purpose is to be served by contrasting two methods of proof which are in no sense opposed the one to the other and each of which is in daily use to complement the other."

Until the early part of the twentieth century, personal injury litigation in England was decided by juries. The rules of procedure relating to jury trial were thus crucial. A defendant was entitled to apply to the trial judge at the conclusion of the plaintiff's case to direct the jury to find for the defendant on the basis that no reasonable jury could find for the plaintiff. The plaintiff's case might have been particularly weak on the facts or on the law.<sup>759</sup>

If the trial judge agreed that the plaintiff's case was so weak, he would dismiss the claim in this way, rather than or let the jury decide it. If, however, the trial judge did not consider that no reasonable jury could find in favour of the plaintiff, he would refuse the defence application and the jury would decide the case.

A judge who refused the defence application to dismiss made on the basis that no reasonable jury could find for the plaintiff would not necessarily have to be of the view that the plaintiff's case should inevitably succeed. The judge might consider that he personally would be disposed to find for the defendant if he were a juror but he might also have to concede that a jury, if it decided in favour of the plaintiff, would not be acting unreasonably.<sup>760</sup>

The jury, when determining the claim after the judge had refused to dismiss it, was perfectly free to decide that case for or against the plaintiff. In many cases, of

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<sup>759</sup> See generally, John Fleming, *The Law of Torts* (9<sup>th</sup> ed, LBC Information Services 1998), at 347. In *Metropolitan Railway Co v Jackson* (1877) 3 App Cas 193, at 207, the plaintiff alleged negligence of his thumb which had been crushed for the slamming of the door of a railway carriage. The defendant was found liable for negligent in allowing the railway to be overcrowded but there was no to suggest that the overcrowding caused the plaintiff's thumb to be where the door was slammed. The House of Lords held that the judge should have withdrawn the case from the jury.

<sup>760</sup> In *Schellenberg v Tunnel Holdings Pty Ltd* (2000) 200 CLR 121, Kirby J (at para 105) stated: "In days when jury trials of factual contests in civil causes were more common in Australia than they are today, the maxim (*res ipsa loquitur*) was an occasional friend to a plaintiff to ensure that the plaintiff got to the jury. It did not, however, ensure a verdict from the jury in the plaintiff's favour. It still remained for the judge to instruct the jury that the plaintiff bore the onus of proving the case on the balance of probabilities and for the jury to conclude whether they should draw the inference which the plaintiff invited."

course, it decided the case in the plaintiff's favour but the refusal of a judge to withdraw the case from the jury was no guarantee of such an outcome.

### *Res Ipsa Loquitur*<sup>761</sup>

As will emerge below, the doctrine of *res ipsa loquitur* can best be explained as a graphic instance of circumstantial evidence sufficiently strong to defeat an application by defence counsel for a direction to dismiss the plaintiff's claim at the closure of the plaintiff's case.

The Court of Exchequer first used the expression *res ipsa loquitur* in *Byrne v Boadle*<sup>762</sup> in 1863. A barrel had fallen from the defendant's premises and injured the plaintiff on the road below. The precise circumstances leading to the accident were not known to the plaintiff. During argument, counsel for the defendant sought a dismissal of the claim on the basis that there was not a scintilla of evidence of negligence. Pollock CB responded: "there are certain cases of which it may be said *res ipsa loquitur* and this seems one of them ..."<sup>763</sup>. The classic exposition of the principles of *res ipsa loquitur* was provided in the case of *Scott v London & St. Katherine Docks Co.*<sup>764</sup> The plaintiff whilst in the discharge of his duty as he was passing in front of a warehouse in the dock, six bags of sugar fell upon him. In

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<sup>761</sup> Bal & Brenner, *Medicolegal Sidebar: The law and Social Values: Res Ipsa Loquitur* (2015) 473 Clinical Orthopaedics & Related Research 23. My analysis of *res ipsa loquitur* is heavily dependent on McMahon & Binchy, *Law of Torts* (4<sup>th</sup> ed, Bloomsbury 2013) at Chapter 9.

<sup>762</sup> (1863) 2 H & C 722; 159 ER 299.

<sup>763</sup> *Byrne v Boadle* (1863) 2 H & C 722; 159 ER 299, Pollock CB in his judgment, stated: "The learned counsel was quite right in saying that there are many accidents from which no presumption of negligence can arise, but I think it would be wrong to lay down as a rule that in no case can presumption of negligence arise from the fact of an accident." This proposition established a rule of evidence which, over time, worked out in practice (though not in legal theory) to transform the negligence action in certain contexts from true fault liability into strict liability. This is especially clear in cases of product liability, somewhat less so in claims for medical negligence. See John Fleming, *The Law of Torts* (9<sup>th</sup> ed, LBC Information services, 1998), at 551-552, states: "[t]he injured consumer is in a singularly disadvantageous position in carrying the burden of proof. To the extent that this has been mitigated by shifting the burden (*res ipsa loquitur*), the law already approaches strict liability and might just as well embrace it openly. Strict liability already controls the relation between buyer and seller; to extend it between manufacturer and ultimate consumer ..."

<sup>764</sup> (1865) 3 H & C 596, at 601; 159 ER 665, at 667.

deciding the requirements for inferring negligence for the purposes of liability, Erle CJ stated:

*“There must be reasonable evidence of negligence. But where the thing is shown to be under the management of the defendant or his servants, and the accident is such as in the ordinary circumstances does not happen if those who have the management use proper care, it affords reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care.”*<sup>765</sup>

*When will the Principle Apply?*

Traditionally, the fundamental requirements of *res ipsa loquitur* applies if it is proved by the plaintiff: (i) that the thing causing the injury was under the management or control of the defendant or his servants, and (ii) that the accident in the ordinary course of things does not happen if those who have the management or control use proper care.<sup>766</sup>

The first of those two requirements, that the “thing” which caused the injury was under the management and control of the defendant, was considered in the decision of the High Court of Australia in *Schellenberg v Tunnel Holdings Pty Ltd.*<sup>767</sup> Kirby J remarked that plaintiff must show that the “thing” (*res*) was under the exclusive management and control of the defendant or someone for whom the defendant is

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<sup>765</sup> *Ibid.*, at 601; 159 ER 665, at 667.

<sup>766</sup> *Scott v London & St. Katherine Docks Co* (1865) 3 H & C 596; 159 ER 665, at 601; 159 ER 665, at 667. See generally, William Binchy, “Issues of Proof in Medical Negligence Litigation: New Questions Posed in the Irish Courts”, Chapter 3 of C Craven & W Binchy eds, *Medical Negligence Litigation: Emerging Issues* (First Law Ltd, 2008) 56.

<sup>767</sup> [2000] HCA 18; (2000) 200 CLR 121.

responsible or whom it has a right to control. If someone else is responsible for the "thing", the plaintiff must establish direct evidence.<sup>768</sup>

In considering whether the 'thing' which caused the injury remained under the management and control of the defendant, Kirby J stated:

*"[T]he 'control' referred to in the authorities is not simply the physical possession of the thing in question. It is such control as imports responsibility for the event which has occurred."*

McMahon & Binchy<sup>769</sup> note the difficulties that can arise in healthcare contexts where there is no actual "thing" such as a scalpel under the control of the defendant other than the patient who was injured by the defendant. They view the relationship of the parties as involving the management or control of the patient, but acknowledge that characterising the patient in such situation as a "thing" is curious. They also express doubt on the clarity of the control test<sup>770</sup>.

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<sup>768</sup> In *Easson v London and North Eastern Railway Company* [1944] 1 KB 421, at 424-425, Goddard LJ held: "... [I]t seems to me it is impossible to say that the doors of an express corridor train travelling from ... are continuously under the sole control of the railway company in the sense in which it is necessary that they should be for the doctrine of *res ipsa loquitur*, or a doctrine analogous to it, to apply. Passengers are walking up and down the corridors during the journey and get in and out at stopping places. ... Before a train leaves a station the company must see that the carriage doors are closed. They are not under an obligation to inspect the off-side doors of the carriages at every stop. There must be reasonable inspection, and they must do the best they can. In my opinion, ... I do not see what other inference could be drawn – that some-one, either out of a spirit of mischief or for some other reason, must have turned the handle of the door and left it open, and if the little boy was in the lavatory immediately adjoining this door he might easily have come out and fallen on the line. ... There was therefore, no evidence of negligence against the company. On the other hand, the evidence seems to me that there was a reasonable inspection and that the door was fitted with a lock of the most modern and approved type which was in perfect working order. Therefore, the door was in a condition which, unless some evilly or officiously disposed person interfered with it, was perfectly safe. The cause of the accident was the opening of the door which must have taken place by some human agency inside the train."

<sup>769</sup> *Law of Torts* (4<sup>th</sup> ed, Bloomsbury Professional 2013) at para 9.20.

<sup>770</sup> *Ibid.*, at para 9.21. "... [a] person may have management or control of a situation in the sense that he or she has legal responsibility for exercising control in respect of it while in no sense exercising, or being capable of exercising, actual hands-on control over every thing or person falling within the remit of that control. For example, a hospital has control of the wards and the patients within them but clearly does not, and should not act in any such a way as to prevent patients (or visitors) from exercising control over their immediate environment. Is it meaningful to enquire whether the hospital is in control of the patient's bed? In one sense, it undoubtedly is: the hospital certainly will have a responsibility if the bed collapses through inadequate maintenance. In another sense, the hospital is not in control

The second requirement of *res ipsa loquitur* is that the accident such as the one that occurred does not usually happen without negligence on the part of the person in control or management. The invocation of this maxim is not based on statistical data on the part of the defendant that accident occurred more often than not but rather evidence must be shown to connect the defendant with the statistical evidence that a certain percentage out of a hundred in which accident of such occurred involved negligence of the defendant.<sup>771</sup>

### *The Procedural Effect of Res Ipsa Loquitur*

This is the most difficult aspect of the maxim on its procedural application where the plaintiff has established the two elements that trigger the application of the *res ipsa loquitur* principle. There are three widely held approaches on the consequences of its procedural application.

According to the first approach, if the plaintiff's case has established that the *res ipsa loquitur* doctrine applies, the plaintiff will be assured that his or her case is sufficiently strong to defeat an application by a defendant to non-suit the plaintiff by directing the jury to find for defendant.<sup>772</sup> The jury in such circumstances will be entitled, but not obliged, to find for the plaintiff.

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of the bed since it cannot prevent a patient with a mechanical bent from taking a ratchet to it, if that is the patient's predilection. Of course, there will be particular contexts where, in the exercise of control by anyone else. Thus, for example, a hospital must ensure that drugs such as morphine are kept under a rigorous system of exclusive control. But most situations of control where *res ipsa loquitur* falls for consideration will be a good deal more attenuated than this."

<sup>771</sup> *Daniels v Heskin* [1954] IR 73, at 79; *Griffin v Patton & Anor* [2004] IESC 46. *Cf Barrett v Southern Health Board* [1988] IEHC 12.

<sup>772</sup> The High Court of Australia in *Mummery v Irvings Pty Ltd* (1956) 96 CLR 99, at 121, rejected the application of *res ipsa loquitur* where plaintiff's evidence is obvious. Dixon J stated: "The rule itself is merely descriptive of a method by which, in appropriate cases, a *prima facie* case of negligence may be made out and we can see no reason why a plaintiff, who is permitted to make out a *prima facie* case in such a way, should be regarded as in any different position from a plaintiff who makes out a *prima facie* case in any other way." The Supreme Court of Canada held a similar view in *Fontaine v British Columbia (Official Administrator)* (1998) 156 DLR (4<sup>th</sup>) 577, at para 26-27, Major J stated: "Whatever value *res ipsa loquitur* may have once provided is gone. Various attempts to apply the so-called doctrine have been more confusing than helpful. Its use has been restricted to cases where the facts permitted an inference of negligence and there was no other reasonable explanation for the accident. Given its limited use it is somewhat meaningless to refer to that use as a doctrine of law. It would appear that the law would be better served if



According to the second approach, the defendant will inevitably lose the case if he or she fails to adduce *some* reasonable explanation consistent with the absence of negligence on his or her part.<sup>773</sup> According to the third approach, the defendant has the burden of proving either that he or she was not negligent or that the plaintiff's injury was caused by some other agency.<sup>774</sup>

A review of the case law throughout the common law world, including Nigeria, reveals that, with the disappearance of juries (in most countries) from personal injuries litigation, the first approach has generally been supplanted by the second or third approach. Courts are not always clear or consistent in their articulation of the procedural effect of *res ipsa loquitur*. This makes analysis of their holdings particularly challenging.

### *Res Ipsa Loquitur in Medical Negligence Litigation*

In England, the courts addressed the application of the *res ipsa loquitur* doctrine in the medical context in three crucial decisions: *Mahon v Osborne*,<sup>775</sup> *Cassidy v Ministry of Health*,<sup>776</sup> and *Roe v Minister of Health*.<sup>777</sup>

Subsequent to *Mahon*<sup>778</sup>, *Cassidy*<sup>779</sup> and *Roe*<sup>780</sup>. English courts have on several occasions<sup>781</sup> held that the *res ipsa loquitur* doctrine was applicable to the facts of

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the maxim was treated as expired and no longer used as a separate component in negligence actions. After all, it was nothing more than an attempt to deal with circumstantial evidence. That evidence is more sensibly dealt with by the trier of fact, who should weigh the circumstantial evidence with the direct evidence, if any, to determine whether the plaintiff has established on a balance of probabilities a *prima facie* of negligence against the defendant. Once the plaintiff has done so, the defendant must present evidence negating that of the plaintiff or necessarily the plaintiff will succeed.”

<sup>773</sup> *Cf Gyan v Ashanti Goldfields Corporation* [1991] 1 GLR 466, Ofori-Boateng JA, (at 481), dissenting.

<sup>774</sup> *Zambia Electricity Supply Co Ltd v Redlines Haulage Ltd* [1992] ZMSC 4.

<sup>775</sup> [1939] 2 KB 14 (CA).

<sup>776</sup> [1951] 2 KB 343.

<sup>777</sup> [1954] 2 QB 66.

<sup>778</sup> [1939] 2 KB 14 (CA).

<sup>779</sup> [1951] 2 KB 343.

<sup>780</sup> [1954] 2 QB 66.

<sup>781</sup> *Bull v Devon Area Health Authority* [1993] 4 Med LR 117, where there was a delay of 50 minutes in obtaining expert obstetric assistance at the birth of twins when the medical evidence was that at the most no more than twenty minutes should elapse between the birth of the first and the second twin; *Coyne v Wigan Health Authority* [1991] 2

the claim against medical personnel; in other cases, the doctrine has been held not to apply<sup>782</sup> on the particular facts.

In *Ratcliffe v Plymouth & Torbay Health Authority & Anor*,<sup>783</sup> the Court of Appeal offered a detailed analysis on the applicability of *res ipsa loquitur* to medical negligence cases<sup>784</sup>. The Court noted that the maxim can apply in simple situations in the medical negligence field<sup>785</sup>, such as where a surgeon cuts off the right foot instead of the left foot or a swab is left in the operation site. In more complex fact situations, the plaintiff evidence is likely to be buttressed by expert evidence, contradicted by expert evidence adduced on behalf of the defendant. Thus, any initial reference based on *res ipsa loquitur* will have been overtaken by a clash of competing expert evidence, to be resolved by the court on conventional principles of the respective weight of each party's evidence. Hobhouse LJ stated:

*“Res ipsa loquitur is not a principle of law: it does not relate to or raise any presumption. It is merely a guide to help to identify when a prima facie case is being made out. Where expert and factual evidence has been called on both sides at a trial its usefulness will normally have long since been exhausted.”*

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Med LR 301, where, following an operation under general anaesthetic, a patient in the recovery ward sustained brain damage caused by hypoxia for a period of four to five minutes, *Brazier v Ministry of Defence* [1965] 1 Lloyd Rep 26, where a needle broke in the patient's buttock while he was being given an injection, *Brown v Merton, Sutton and Wandsworth Area Health Authority* [1982] 1 All ER 650, where the claimant developed quadriplegia following the administration of an epidural anaesthetic, in the course of preparation for giving birth. See Jones Michael, *Medical Negligence* (4<sup>th</sup> ed, Sweet & Maxwell 2008), at 3-146, from which these citations are derived.

<sup>782</sup> *Fish v Kapur* [1948] 2 All ER 176: when a dentist left part of the root of a tooth behind during an extraction and broke the claimant's jaw, *Whitehouse v Jordan* [1980] 1 All ER 650, at 658, 661: where a baby suffered cerebral palsy following a forceps delivery.

<sup>783</sup> [1998] Lloyd's Rep Med 162.

<sup>784</sup> *Ibid.*, at para 49(1)-(7).

<sup>785</sup> *Ibid.*, at para 49(2), states: “In principle, the maxim can be applied in that form in simple situations in the medical negligence field (surgeon cuts off right foot instead of left; swab left in operation site; patient wakes up in the course of surgical operation despite general anaesthetic).”

### *Canada's Rejection of the Res Ipsa Loquitur Doctrine*

In *Fontaine v British Columbia (Official Administrator)*,<sup>786</sup> the Supreme Court of Canada rejected the entire doctrine of *res ipsa loquitur* as being, on balance, unhelpful to clear analysis. Major J stated:

*“Whatever value res ipsa loquitur may have once provided is gone. Various attempts to apply the so-called doctrine have been more confusing than helpful. Its use has been restricted to cases where the facts permitted an inference of negligence and there was no other reasonable explanation for the accident. ... It would appear that the law would be better served if the maxim was treated as expired and no longer used as a separate component in negligence actions.”*<sup>787</sup>

### *Res Ipsa Loquitur in African Medical Negligence Litigation*

Let us now consider how African courts have applied the doctrine of *res ipsa loquitur* in medical contexts. The position is that there has been a wholesale endorsement of English case law on the subject, but with little attempt to reflect on the nuances of the differing approaches to the procedural implications of application of *res ipsa loquitur*. Thus one finds African judicial authority for treating *res ipsa loquitur* variously as being sufficient to defeat a motion for

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<sup>786</sup> [1998] 1 SCR 424.

<sup>787</sup> *Ibid.*, at para 26-27. The Ontario Court of Appeal reaffirmed the rejection of *res ipsa loquitur* to infer negligence from circumstantial evidence in regard to tooth extraction in the case of *Dickie v Minett* (2014) ONCA 265, holding that a patient's jaw could break during surgery in spite of the use of reasonable care, and failure of the plaintiffs' expert witness to identify the risk factors in tooth extraction. Rosenberg JA (at para 3) noted: "While there remain cases in which circumstantial evidence can raise an inference of negligence which calls for an explanation from the defendant, the plaintiffs have not persuaded [the Court] that the trial judge erred in concluding that the evidence did not reach that threshold ..."

dismissal, as requiring the defendant to adduce *some* explanation or as imposing a full onus of proof on the defendant to establish the absence of negligence or of causal responsibility for the patient's injuries.

In Nigeria, in *Abi v Central Bank of Nigeria & Ors*,<sup>788</sup> the plaintiff, an employee of the first named defendant, took ill and was taken to the second named defendant hospital. He alleged that he had been negligently diagnosed with cerebrospinal meningitis (CSM) and administered on him various drugs, including gentamycin which made him permanently deaf due to complication of the drugs. The plaintiff pleaded *res ipsa loquitur*. The Court of Appeal held that the plaintiff had failed to establish negligence<sup>789</sup>. The Court noted that *res ipsa loquitur* would have applied had the plaintiff established that wrong administration of gentamycin would have been avoided without negligence. Nwodo JCA concluded:

*“Unfortunately ... there is no direct credible evidence on which the court can infer what caused the loss of hearing. The plea of res ipsa loquitur would have been available to the plaintiff if he adduced evidence to show that the injury would not have happened without likelihood of lack of care by the defendant. It is after the plaintiff has established evidence from which negligence is inferred that the burden shifts to the defendants to rebut any presumption of negligence.”*<sup>790</sup>

In *Plateau State Health Services Management Board & Anor v Philip Fitoka*,<sup>791</sup> the plaintiff, an Inspector of Police, was taken ill and went to the second defendant's

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<sup>788</sup> [2012] 3 NWLR 1.

<sup>789</sup> *Ibid.*, at 37-38, Nwodo JCA stated: “There is no reasonable evidence adduced to show [that] the defendants did not act in accordance with practice accepted for the treatment of meningitis diagnosed. The sole testimony of the plaintiff certainly could not *per se* amount to proof of the particulars of negligence pleaded against the defendants.”

<sup>790</sup> *Ibid.*, at 38.

hospital for treatment for pneumonia. After the administration of drugs on him, he became completely deaf. He brought a claim in negligence and successfully pleaded *res ipsa loquitur* against the defendants. Alagao JSC concluded:

*“[T]he evidence led by the plaintiff and lack of same by the defendants having chickened out of an opportunity to state their own position ... and the sheer force of the other exhibits ... having been rejected, the defendants were properly found liable in negligence and res ipsa loquitur applied.”*

This would appear to represent a clear instance of the second of the three approaches to the procedural effect of *res ipsa loquitur* which have been identified earlier. The failure of the defendants to have availed themselves of the opportunity to provide some plausible explanation of the plaintiff’s injury consistent with the absence of negligence on their part was fatal to their defence.

In *Lagos University Teaching Hospital v Yemi Lawal*,<sup>792</sup> the plaintiff was the respondent who was admitted into the first defendant hospital for incomplete miscarriage. The plaintiff claimed that, while on admission, she had become infected through a drip which was inserted into wrong spot of her right thumb by the second defendant and had become gangrenous and was subsequently amputated after other treatments had failed. The plaintiff argued that the first defendant was vicariously liable for the negligence of the second defendant and she pleaded *res ipsa loquitur* in the alternative.

The trial court relieved the second defendant of liability and held that:

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<sup>791</sup> [2013] 2 NWLR 383.

<sup>792</sup> (1982) 3 FNR 184.

*“[A]pplying the principle of res ipsa loquitur, ... the right hand of the plaintiff which was sound before she went into hospital for treatment, could not have been damaged but for the negligence of the other servants or agents of the first defendant.”*<sup>793</sup>

The trial judge reached this conclusion on the premise that plaintiff had established a *prima facie* presumption of negligence against the first defendant that those who attended the plaintiff in whose charge she was, were the servants of the first defendant. On appeal, the Court of Appeal reversed the decision of the trial court for failure to weigh the totality of evidence adduced by both parties before reaching the conclusion that the first named defendant had failed to rebut the presumption of negligence and held that that defendant had rebutted the presumption of negligence and *res ipsa loquitur* did not apply. Kazeem JCA stated:

*“Having regard to the foregoing I am satisfied that the defendant has taken the trouble to give reasonable explanation as to what could have caused the plaintiff’s condition, most of which the learned trial judge did not consider. It is noteworthy that the plaintiff originally based her case on the negligence of the second defendant which she failed to prove, and that no other servant or agent of the defendant was found negligent by the Court. In the circumstances, I am firmly of the view that the principle of res ipsa loquitur is inapplicable in this case.”*<sup>794</sup>

In *Ojo v Gharoro & Ors*,<sup>795</sup> the plaintiff had been unable to get pregnant and went to hospital where it was medically ascertained that the removal of a growth might

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<sup>793</sup> *Lagos University Teaching Hospital v Yemi Lawal* (1982) 3 FNR 184, at 189.

<sup>794</sup> *Lagos University Teaching Hospital v Yemi Lawal* (1982) 3 FNR 184, at 195.

make it possible for her to have a pregnancy. The surgical procedure was done by the first defendant who was assisted by the third defendant. The defendants negligently left in the plaintiff's womb a broken needle as a result of which she experienced great pains. The plaintiff brought action and pleaded *res ipsa loquitur*. The Supreme Court held that the plaintiff's failure to call an expert witness was fatal to her case. The Court found on the basis of the evidence that the defendants had rebutted the presumption of negligence<sup>796</sup> that needles break often in surgical operations. Tobi JSC concluded:

*“From the totality of the case before the trial court, I believe the evidence of the defendants that ‘the needle in this case got broken accidentally and proper care was taken to locate the pieces’.”*<sup>797</sup>

In the Ghanaian case of *Asantekramo alias Kumah v Attorney-General*,<sup>798</sup> the plaintiff was referred by her private medical practitioner to the defendants' hospital, having been diagnosed as suffering from a ruptured ectopic pregnancy. The plaintiff was examined there and an urgent operation was recommended. The operation was successful, but her right arm became swollen and gangrenous, resulting in its eventual amputation, following a blood transfusion administered on her by the nursing staff, through a vein in that arm. The High Court held that the onus of proof shifted on the defendants to show that the gas gangrene which developed had occurred through no fault of the doctors and nurses or those persons who took charge of the plaintiff<sup>799</sup>. Imposing liability, Taylor J stated:

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<sup>795</sup> [2006] 10 NWLR 173.

<sup>796</sup> *Ibid.*, at 210, Tobi JSC remarked: “In the circumstances, I have no difficulty in coming to the conclusion that the presumption of negligence on the part of the defendants was clearly rebutted by the evidence ...”

<sup>797</sup> *Ibid.*, at 216.

<sup>798</sup> [1975] 1 GLR 319.

<sup>799</sup> *Asantekramo alias Kumala v Attorney-General* [1975] 1 GLR 319, at 334.

*“[N]o evidence of any sort was led by the defendant as to whether the needle used and the apparatus were sterilized. Evidence was not led that the dextrose drip and the blood given were not contaminated.”*<sup>800</sup>

In another Ghanaian decision, *Asafo v Catholic Hospital of Apam*,<sup>801</sup> the High Court likened the disappearance of the plaintiff’s six weeks old daughter whilst she was on admission as in-patient in a special ward at the defendant’s hospital for treatment to a case of bailment.<sup>802</sup> Edward Wiredu J stated:

*“In matters of care, attention and control of movements a child of six weeks old is no different from an inanimate object which is incapable of independent movement but depends for such support on whoever have its custody. Where therefore the child gets missing whilst under somebody’s custody conditions exist which require an explanation from whoever had its custody.”*<sup>803</sup>

The court considered that the facts demanded a reasonable explanation for the disappearance of the child from the hospital. It held that *res ipsa loquitur* could be applied in the light of the exclusive knowledge of the defendant regarding an event

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<sup>800</sup> *Ibid.*, at 340.

<sup>801</sup> [1973] 1 GLR 282.

<sup>802</sup> In a similar circumstances, the High Court of Kenya, Nairobi in *Muchoki v Attorney-General* [2004] 2 EA 178, held the defendant liable for disappearance and subsequent death of the plaintiff’s four years old daughter who was on admission as in-patient in the defendant’s hospital. Visram J stated (at 179): “According to evidence adduced it is abundantly clear that the child was left in the care of the hospital, that sometime between 5.30pm (after the departure of the child’s mother) and the following morning, the child strayed out of the hospital and was found dead by the river, still wearing a hospital uniform. In my view, this is a case where the doctrine of *res ipsa loquitur* applies. The plaintiff having established that the child was left in the care of the defendant hospital, it was then upon the hospital to prove that there was no negligence on its part, or on the part of its servant. This it failed to do.”

<sup>803</sup> *Asafo v Catholic Hospital of Apam* [1973] 1 GLR 282, at 286.



which occurred such as would not in the ordinary course of things have occurred without negligence. Wiredu J stated:

*“I find res ipsa loquitur applicable to the facts of the present case, and in the absence of any evidence from the defence to show how the child disappeared or to show that the disappearance consistent with due diligence on their part or that there was no lack of reasonable care on the part of the hospital staff in their custody of the child, I hold the defence liable to the plaintiff in damages.”<sup>804</sup>*

In South Africa, the jurisprudence, modelled on the Roman Dutch law, was traditionally reluctant to apply *res ipsa loquitur* to delictual claims for medical negligence. In *Van Wyk v Lewis*,<sup>805</sup> a swab was left in the plaintiff’s womb after an appendectomy and gall bladder operation. The Court held that the application of *res ipsa loquitur* is not applicable.<sup>806</sup>

In the subsequent cases, courts in recent times are willing to retreat from *Van Wyk*.<sup>807</sup> Brand JA in *Buthelezi v Ndaba*,<sup>808</sup> noted that the findings of the Court in

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<sup>804</sup> *Ibid.*, at 286.

<sup>805</sup> 1924 AD 438.

<sup>806</sup> For criticism, see Patel B, *Medical negligence and res ipsa loquitur in South Africa* (2008) 1 South African Journal of Bioethics and Law 57, at 59.

<sup>807</sup> *Ntsele v MEC for Health, Gauteng Provincial Government* [2013] 2 All SA 356 (GSJ), at para 123-124, the court held that *res ipsa loquitur* is applicable having regard to the constitutional right of the plaintiff to access adequate reproductive healthcare. Pieter Carstens, *Judicial Recognition of the Application of the maxim Res ipsa loquitur to a case of Medical Negligence: Lungile Ntsele v MEC for Health, Gauteng Provincial Government* (2013) *Obiter* 348, at 357-358, remarks: “... it can be stated that, although South African courts have consistently followed the approach adopted by the majority in *Van Wyk v Lewis* 1924 AD 438, it is submitted that this judgment can no longer be supported as a general blanket denial of the doctrine’s application to medical negligence cases especially in view of the fact that it seems that the court based its most important finding in the judgment on a material misdirection in respect of the expert medical evidence tendered at the trial. The paternalistic notion that all medical procedures fall outside the common knowledge or ordinary experience of the reasonable man is not only outdated but untenable. In certain instances of medical accidents it is totally unnecessary to have regard to the surrounding circumstances as such an occurrence itself is almost conclusive proof of negligence, for example, the erroneous amputation of a healthy limb. ... It seems that there is little justification for the fact that, in South Africa, the victim for example of an aircraft or motor accident should be able to make use of the doctrine to alleviate his or her evidential burden whereas the victim of a medical accident is constantly faced with an unjustified and inequitable denial of its application. In

the *Van Wyk* case never suggested that the application of *res ipsa loquitur* could not apply in medical negligence claims but, it “could rarely, if ever, find application in cases based on alleged medical negligence”<sup>809</sup>. In this regard, the inference of negligence could be invoked on the facts of the case in question if supported by evidence which the defendant failed to rebut.

In the later case of *Goliath v MEC for Health, Eastern Cape*,<sup>810</sup> the Supreme Court of Appeal expressed its willingness to infer negligence on the part of the defendant in a medical negligence claim where the defendant had left a swab in the plaintiff’s womb, although the Court emphasised that the onus of proof was not thereby shifted to the defendant. The Court’s attitude to *res ipsa loquitur* was not greatly different from that adopted by the English and Canadian courts in recent years: not to be fixated by technical rules regarding onus of proof but rather to come to a considered judgment at the conclusion of the case when all the evidence had been given.

It is interesting that the South African Supreme Court in *Wagener v Pharmacare Ltd; Cuttings v Pharmacare Ltd*,<sup>811</sup> was willing to envisage the continuing vitality of the *res ipsa loquitur* doctrine when it rejected the plaintiff’s claim that the protection of people’s constitutional rights to life and bodily integrity required that the Aquilian action in negligence in respect of product liability be replaced by a strict liability regime. The Court held that such a change in the law was so complex that it was within the exclusive competence of the legislature. Howie J stated:

“[T]he plaintiff’s remedy is confined to the Aquilian action which is

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the wake of an alarming increase of medical negligence concerning obstetric, paediatrics and neonatologists in hospital in South Africa, this judgment is to be welcomed ...”

<sup>808</sup> [2013] ZASCA 72.

<sup>809</sup> *Ibid.*, at para 16.

<sup>810</sup> [2014] ZASCA 182

<sup>811</sup> [2003] ZASCA 30. This decision is also considered in the chapter on Product Liability, above.

*presently adequate to protect her right to bodily integrity, both as it is and given the opportunity for incremental development of the approach to res ipsa loquitur and to the incidence of the onus. If strict liability is to be imposed it is the legislature that must do it.*”<sup>812</sup>

### *The Best Way Forward?*

Let us briefly consider the best way forward for Nigerian courts. One approach would be to follow the lead of the Supreme Court of Canada and abolish the distinctive doctrine of *res ipsa loquitur* on the basis that it is merely a specific instance of circumstantial evidence. In favour of this approach, it may be argued that it removes the uncertainties and incoherence of the *res ipsa loquitur* doctrine, which have resulted in arbitrary outcomes for patients. As against this, the problem of an unexplained injury sustained in the course of medical treatment is a graphic instance of the imbalance of power and knowledge as between patients and healthcare providers. The *res ipsa loquitur* doctrine is a useful means of reducing that imbalance of power – more effectively than the conventional application of the rules relating to circumstantial evidence generally. Patients in Nigeria are at a serious disadvantage in many cases in terms of education and economic power. The *res ipsa loquitur* doctrine, when it imposes a burden of proof on defendants to show that the injury was not caused by their negligence, either on grounds of lack of causation or lack of negligence on their part, seems a just rule which is not disproportionately tilted in the patient’s favour. The healthcare providers are generally in a better position to provide the explanation for what happened.

Accordingly, it is recommended that Nigeria should adhere to the doctrine of *res ipsa loquitur*, on the basis that its procedural effect should be to impose such a

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<sup>812</sup> *Ibid.*, at para 38.

burden on defendants. No doubt, in many cases at the end of the proceedings, the inference of negligence generated by *res ipsa loquitur* will have been displaced by specific evidence adduced by competing expert witnesses but, it is respectfully submitted, that is no reason for abandoning the doctrine completely.

## **Chapter Fourteen**

### **The Limitation Period in Medical Negligence Claims**

#### *Introduction*

In this Chapter, I examine how the limitation of actions operates in Nigeria and other jurisdictions, with particular emphasis on its operation in medical negligence litigation. England's Limitation Act 1623 applied as a "statute of general application" to common law jurisdictions. The Limitation Act 1623 remained in force in England without substantial amendment until 1939. A further substantial reform was brought about by Statute of Limitations Act 1980.

Other common law jurisdictions, including Nigeria, modelled their Statutes of Limitations on the Limitation Act 1939,<sup>813</sup> taking the position that a cause of action

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<sup>813</sup> Section 2(1) provided: that an action founded on tort should not be brought after the expiration of six years from the date on which the cause of action accrued.

accrues on the date on which the incident giving rise to cause of action occurs.<sup>814</sup> This approach may be contrasted with a discoverability test of damage arising from the tortious conduct.<sup>815</sup> Under a discoverability test, the limitations clock does not begin to tick until the injured party could first have become aware of the injury and its attributability to the defendant's conduct. In some jurisdictions, such as Ireland, the clock begins to tick when such attribution could first be made as a factual matter – that the defendant, as a matter of *fact* was the author of the damage. In other jurisdictions, such as Britain, such attribution must be of a *legal* character – that the defendant was guilty of legal wrong.

Limitation of actions in contract arises when the contract is breached irrespective of when the damage occurs, unlike an action in tort which gives rise to cause of action, at the earliest, when the damage is suffered.

Generally, the limitation period for actions in contract or tort is six years, except for actions in tort for personal injuries, where the period tends to be shorter – two or three years, depending on the legislation. The reason for this disparity in limitation periods has been identified as resting on the fact that victims of personal injury need to be compensated within a reasonable time, but this is scarcely a sound justification for *curtailing* the right of action of victims of personal injuries by such a short limitation period.

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<sup>814</sup> *Justina Alfred & Anor v The Minister, Federal Capital Territory & Ors* (24 January 2011), HC, FCT Abuja, Nigeria.

<sup>815</sup> In *McDonnell v Congregation of Christian Brothers Trustees & Ors* [2004] 1 AC 1101, at para 9, the House of Lords stated: “[T]he Limitation Act 1939 made provision for postponement of the running of time in the case of fraud, fraudulent concealment or mistake, the Act made no comparable provision for a case in which a potential plaintiff was unaware, at the time of suffering injury or before expiry of the limitation period, that he had suffered any injury, or any significant injury, or that any link existed between the suffering of injury and the conduct of another. Since, on accepted principles, a cause of action in tort accrues on the suffering of damage, the possibility existed that a claim would be statute-barred before the victim became aware that he had any cause of action on which he could sue.”

In a claim of medical negligence, limitation period in a number of countries has been extended by a discoverability test, which delays the commencement of the Statutes of Limitations.

The courts in common law countries have held four different views on the construction of the statute to determine the time when a cause of action accrues in the context of negligence. The first is that a cause of action accrues when damage caused by wrongful act occurs.<sup>816</sup> The second view is that a cause of action accrues when plaintiff could first reasonably have become aware of the damage.<sup>817</sup> The third view holds that a cause of action accrues when plaintiff could first reasonably have become aware of the damage and the fact that the damage was caused by the defendant.<sup>818</sup> The last view is that a cause of action accrues when plaintiff could first reasonably have become aware of the damage and the fact that the damage was caused by the defendant and also that the defendant was legally to blame.<sup>819</sup> The latter approach is clearly the most liberal towards plaintiffs.

In Nigeria, the Lagos State Limitation Law 1994 contained a number of provisions in respect of actions claiming damages for negligence *etc*, where damages consist of or include personal injuries<sup>820</sup>. However, the limitation law failed to make any

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<sup>816</sup> *Pirelli General Cable Works Ltd v Oscar Faber & Partners* [1983] 2 AC 1.

<sup>817</sup> *Cartledge v E. Jopling & Sons Ltd* [1963] AC 758.

<sup>818</sup> Purchas LJ in *Nash v Eli Lilly & Co* [1993] 1 WLR 782, at 792, stated: "... we shall proceed on the basis that knowledge is a condition of mind which imports a degree of certainty and that the degree of certainty which is appropriate for this purpose is that which, for the particular plaintiff, may reasonably be regarded as sufficient to justify embarking upon the preliminaries to the making of a claim for compensation such as the taking of legal or other advice."

<sup>819</sup> The English Court of Appeal in *Spargo v North Essex District Health Authority* [1997] 37 BMLR 99; [1997] PIQR P235, at P242, developed what the law required in order to establish actual knowledge. Brooke LJ stated: "A plaintiff has the requisite knowledge when she knows enough to make it reasonable for her to begin to investigate whether or not she has a case against the defendant. Another way of putting this is to say that she will have such knowledge if she so firmly believes that her condition is capable of being attributed to an act or omission which she can identify (in broad terms) that she goes to a solicitor to seek advice about making a claim for compensation."

<sup>820</sup> Lagos State Limitation Law (CAP. 118) Part 2. Actions in Contract and Tort and Certain Other Actions: 9(1) This section applies to actions claiming damages for negligence, nuisance, or breach of duty (whether the duty exists by

reference by definition of what constitutes "date of knowledge" of the plaintiff in the context of material facts which caused damage. Be that as it may, it is clear that the cause of action starts to run when damage caused by the wrongful act occurred without reference to when the damage was discovered.

In *Michael Kolawole v Pezzani Alberto*,<sup>821</sup> the Supreme Court of Nigeria examined the *ex parte* application brought by the plaintiff arising from the motor traffic accident caused by the defendant. The Writ of Summons had not been served on the defendants until after some months due to the initial defective of court's order. The Supreme Court held that the plaintiff's cause of action arose over a decade previously and it would be futile to renew a Writ which was incapable of supporting a valid cause of action<sup>822</sup>. In *Justina Alfred & Anor v The Minister, Federal Capital Territory & Ors*,<sup>823</sup> the plaintiff attended the ante-natal clinic of the defendants' hospital where she was negligently treated by the third defendant

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virtue of a contract or of a provision made by or under an enactment or independently of any contract or of any such provision), where the damages claimed by the plaintiff for the negligence, nuisance, or breach of duty consist of or include damages in respect of personal injuries to any person. (2) Subject to the provisions of this section, no action to which this section applies shall be brought after the expiration of three years from the date on which the cause of action accrued. (3) Subsection (2) of this section shall not afford any defence to an action to which this section applies in so far as the action relates to any cause of action in respect of which – (a) the court has, whether before or after the commencement of the action granted leave for the purposes of this section; and (b) the requirements of subsection (4) of this section are fulfilled. (4) The requirements of this subsection are fulfilled in relation to a cause of action if it is proved that the material facts relating to that cause of action were at all times outside the knowledge (actual or constructive) of the plaintiff until a date which – (a) either was after the end of the three-year period relating to that cause of action or was not earlier than twelve months before the end of that period; and in either case, was a date not earlier than twelve months before the date on which the action was brought. (5) Nothing in this section shall be construed as excluding or otherwise affecting – (a) any defence which, in any action to which this section applies, may be available by virtue of any enactment other than subsection (2) of this section (whether it is an enactment imposing a period of limitation or not, or by virtue of any rule of law or equity; or (b) the operation of any enactment or rule of law or equity which, apart from this section, would enable such an action to be brought after the end of the period of three years from the date on which the cause of action accrued. (6) Any application for the leave of the court for the purposes of subsection (3) of this section shall be made in accordance with rules of court and such rules may define the facts to be taken into consideration by the court in granting or refusing to grant the application. (7) In this section "the court" in relation to an action means the court in which the action has been, or is intended to be, brought.

<sup>821</sup> (1989) NWLR (Pt. 98) 382.

<sup>822</sup> *Ibid.*, Craig JSC stated: "The position ... is that although the cause of action arose in 1976 (13 years ago), plaintiff has not been able to serve the defendant with the Writ of Summons. For this lapse, he relied on the ineptitude of his Solicitor's Clerk, and the Court of Appeal has found that this excuse was not a sufficiently good reason. Furthermore, by the Lagos State Statute of Limitation, the action had become statute-barred in 1979; some 10 years ago."

<sup>823</sup> (24 January 2011) HC, FCT Abuja, Nigeria.

who carried out caesarean section upon her. She was feeling abdominal pain after her discharge from the hospital and brought a claim for continuing injury. The defendants contended that they were public officers, seeking protection under the Public Officers Protection Act 2004 which bars a claim three months after the cause of action arose. The court adhered to the traditional view that a cause of action accrues on the date which the incident giving rise to the claim occurs.

In Kenya, the Court of Appeal at Nakuru in *Gatune v The Headmaster, Nairobi Technical High School & Anor*<sup>824</sup> considered when the date of knowledge occurs. In this case, the plaintiff was a secondary school teacher in the defendant's employment. In the course of performing experiments as a science teacher in the school's laboratory in May 1970, he fell unconscious and experienced failure of his optic nerves and he was taken to Kenyatta National Hospital, where he received treatment for three weeks before he was flown abroad in Moscow, where he was treated and found to have suffered permanent incapacity to his eyesight. A certificate to that effect was issued on 6<sup>th</sup> August 1976. The plaintiff argued that he was not aware that he had become totally blind until he received his medical certificate on his treatment in Moscow. The trial court held against the plaintiff, taking the view that the facts of the case were not outside the knowledge of the plaintiff. The Court of Appeal reversed the findings of the trial court. Nyarangi JA, delivered the majority judgment, he stated:

*“[A]lthough the plaintiff was aware of the injury to his eyes ..., that knowledge alone did not in the circumstances to his case constitute material facts relating to the cause of action. The plaintiff underwent considerable medical treatment here and [abroad] before the medical report that he had lost eye-sight in both eyes was issued. The medical*

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<sup>824</sup> [1988] KLR 561.



*report which came to the knowledge of the plaintiff early ... included a fact of decisive character – ie total loss of eye-sight which was outside the plaintiff’s knowledge ...*”<sup>825</sup>

Nyarangi JA concluded:

*“In my judgment the trial judge erred in finding that the material facts which facts the trial judge considered far too narrowly, were not outside the knowledge of the plaintiff. The plaintiff acted reasonably in seeking medical treatment than in obtaining legal advice with a view to filling an action.”*<sup>826</sup>

In *Humphrey Kiriungi Njagi v Aga Khan Health Services*,<sup>827</sup> the High Court of Kenya, Nairobi placed considerable reliance on *Gatune’s* case in holding that a cause of action arises upon manifestation or discoverability of the injury<sup>828</sup>.

In *William Richard Kutai v Kenya Railways Corporation*,<sup>829</sup> the plaintiff worked for the defendant as a train guard. In the course of his duty while he was travelling in such capacity in a goods train there was an accident and he suffered head injuries, including back pain and injury to his legs. The defendant argued that the plaintiff’s claim was statute barred. The plaintiff replied that he could not be considered to have known of his injury until he was aware of a medical report

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<sup>825</sup> *Ibid.*, at 569.

<sup>826</sup> *Gatune v The Headmaster, Nairobi Technical High School & Anor* [1988] KLR 561, at 569.

<sup>827</sup> [2005] eKLR.

<sup>828</sup> *Ibid.*, eKLR, J. B. Ojwang J stated: “The cause of action may not be obvious, or may be so extended or so dynamic that it cannot be marked as elapsed over one single day. The cause of action in healthcare matters, for instance, cannot realistically be assigned to one single act occurring on a particular day, and for which one individual takes the blame. The reference point in such a situation must be when the harm was sustained by the claimant; and the relevant date may be somewhat removed from the date when a particular act of medical care took place.”

<sup>829</sup> [2009] eKLR.

written by the doctor who had attended to him. The High Court of Kenya held that the claim was indeed statute barred. Sitati J stated:

*“I do not think that the plaintiff’s case is one of coming out of continuous cause of action or that there were decisive facts unknown to the plaintiff. There are no circumstances to suggest that there was any material that was not within the knowledge of the plaintiff until expiry of the statutory period. Nor is there evidence to show that the tort against the plaintiff was one of a continuous nature.”*<sup>830</sup>

The limitation of actions in South Africa is regulated by the Prescription Act 68 of 1969<sup>831</sup> which specifies the limitation periods for “delictual debt” (the obligation to do something or to abstain from doing something)<sup>832</sup>, including personal injury claims. In *Truter & Anor v Deysel*,<sup>833</sup> the plaintiff brought an action against the defendants for damages arising from personal injuries allegedly suffered as a result of a series of surgical operations performed on him. The issue considered in the appellate court was when the plaintiff had knowledge of the facts of the damage at which prescription started to run. The plaintiff argued that prescription started running when he had knowledge of the damage five years later through an expert doctor, whom he heard on a radio “talk show” and discussed the problem with the

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<sup>830</sup> *William Richard Kutai v Kenya Railways Corporation* [2009] eKLR, at para 25.

<sup>831</sup> The relevant sections of the Act read as follows: s. 11(d) Periods of prescription: save where an Act of Parliament provides otherwise, three years in respect of any other debt; s. 12 When prescription begins to run – (1) Subject to the provisions of sub-sections (2) and (3), prescription shall commence to run as soon as the debt is due. (2) If the debtor wilfully prevents the creditor from coming to know of the existence of the debt, prescription shall not commence to run until the creditor becomes aware of the existence of the debt. (3) A debt shall not be deemed to be due until the creditor has knowledge of the identity of the debtor and of the facts from which the debt arises: Provided that a creditor shall be deemed to have such knowledge if he could have acquired it by exercising reasonable care.

<sup>832</sup> *Road Accident Fund & Anor v Mdeyide* [2010] ZACC 18, at para 11.

<sup>833</sup> [2006] ZASCA 16.

doctor. At trial court, this piece of evidence was found weighty for the plaintiff<sup>834</sup>. However, the appellate court rejected the findings of the trial court. Van Heerden JA stated:

*“A debt is due in this sense when the creditor acquires a complete cause of action for the recovery of the debt, that is, when the entire set of facts which the creditor must prove in order to succeed with his or her claim against the debtor is in place or, in other words, when everything has happened which would entitle the creditor to institute action and to pursue his or her claim.”*<sup>835</sup>

The court went further, rejecting the expert opinion of the plaintiff as a piece of evidence rather than knowledge of facts from which the debt arises<sup>836</sup>. The Court, in finding for the defendants, noted that the plaintiff had had knowledge of facts that a wrong had been done to him by the defendants at an earlier stage and acknowledged that prescription started to run when the plaintiff became aware of facts necessary to support a claim that a wrong had been done. The appellate court held that the cause of action was complete and the debt of the defendants became due as soon as the *first known* harm was sustained by the plaintiff, notwithstanding the fact that the loss of his right eye occurred later<sup>837</sup>.

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<sup>834</sup> *Truter & Anor v Desyel* [2006] ZASCA 16, at para 14, Van Heerden JA quoted a passage from the trial court where Mlonzi AJ stated: “It is not legally conceivable how a malpractice case will see its day in South African court of law without the litigant obtaining knowledge of a medical expert that indeed the symptoms complained about or the resultant consequences is indicative of some degree of incompetence or negligence constituting the wrongful act.”

<sup>835</sup> *Truter & Anor v Desyel* [2006] ZASCA 16, at para 15.

<sup>836</sup> *Ibid.*, at para 19, Van Heerden JA stated: “[T]he presence or absence of negligence is not a fact; it is a conclusion of law to be drawn by the court in all the circumstances of the specific case. Section 12(3) of the Act requires knowledge only of the material facts from which the debt arises for the prescriptive period to begin running – it does not require knowledge of the relevant legal conclusions (*ie* that the known facts constitutes negligence) or of the existence of an expert opinion which supports such conclusions.”

<sup>837</sup> *Ibid.*, at para 22. Similarly in *Links v MEC, Department of Health, Northern Cape Province* [2013] ZANCHC 26, the plaintiff injured his left thumb through dislocation and attended the defendant’s hospital where a POP was cast

In *Mbodla v MEC for Health, Eastern Cape Province*,<sup>838</sup> may be contrasted with *Truter*. In this case, the plaintiff had a traffic accident and was treated at the defendant's hospital. His ailments worsened over time. Eventually he consulted attorney five years after the accident. The defendant argued that the facts had become known to the plaintiff the day he attended hospital for treatment. The High Court held, however, that the case was distinguishable from the *Truter* case and that the claim was not defeated by prescription. Griffiths J stated:

*“The present matter is very different [from Truter]. The hospital treatment given the plaintiff and the evidence (in the form of the clinical notes) as to such treatment is clearly lacking in the extreme and unlikely to inform a layman of the fact that the plaintiff received less than optimal treatment. ... To my mind, the fact that he experienced progressive pain and was aware of the deformity, together with his difficulty in squatting ... could not have been sufficient, without more, to have indicated to him, as a layman, that sub-optimal treatment had been administered.”*<sup>839</sup>

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and asked to return ten days after to remove the plaster cast. However, he returned earlier to the hospital on two different occasions before the date he was asked to come back as a result of continuous in the arm and eventually amputated on the third occasion. The issue in discussion by the High Court of South Africa was whether the plaintiff had actual or deemed knowledge of the facts from which the debt arises. Mamosebo AJ (at para 26), stated: “The plaintiff in this case became aware of the amputation ... He had suspected prior to this date while still in hospital that something was not right. In my view, plaintiff ought reasonably to have realised ... that the operation was not successful; alternatively that the subsequent treatment was not properly done or that there was no proper remedial medical follow up action. The plaintiff's knowledge can be imputed to him from the time the last plaster cast was removed. From the papers I have not discerned any event that interrupted or could be construed to have interrupted the running of the prescription.”

<sup>838</sup> [2014] ZASCA 60.

<sup>839</sup> *Ibid.*, at para 28.

The Supreme Court of Appeal overturned the High Court judgment and held that the question of prescription could not be determined without recourse to the oral evidence of both parties. Wallis JA stated:

*“In those circumstances it was inappropriate for the court below to reach a final conclusion on the issue of prescription and compliance with the statute on the papers alone. The fault for the shortcomings in the evidence was attributable to both parties. [Plaintiff’s] founding affidavit needed to be more forthcoming in regard to the history of events and it can rarely, if ever, be the case that a question of prescription, involving constructive knowledge of certain facts, can be resolved as a question of law alone. The [defendant] should have placed facts before the court to substantiate the plea of prescription.”*<sup>840</sup>

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<sup>840</sup> *Mbodla v MEC for Health, Eastern Cape Province* [2014] ZASCA 60, at para 6.

## Chapter Fifteen

### Mediation and other Alternative Dispute Resolution (ADR) Strategies

At this point, it may be useful to consider whether Nigeria should introduce mediation or other ADR strategies as an alternative, or supplement, to medical negligence litigation.<sup>841</sup> Such approaches have found some support internationally. ADR offers the parties a quick and private means of resolving their dispute. This may be particularly attractive to medical health professionals for whom the publicity of High Court proceedings is likely to damage their reputation, even if (months or years later) the court holds in their favour.

ADR also gives some advantages to patients, who, under present conditions in Nigeria, simply do not have the resources or skill to present convincing expert evidence to the court. Moreover, often injured patients are seeking explanations (as well as apologies in some cases). They are by no means invariably looking for a high award of damages. The ADR system might be a better route to obtain such explanations.

One should, however, be conscious of the challenges that ADR strategies pose for patients. Generally, mediated settlements reflect rather than contradict the balance

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<sup>841</sup> See generally, Ayinla Lukman, *Enhancing Sustainable Development By Entrenching Mediation Culture in Nigeria* (2014) 21 *Journal of Law, Policy and Globalization* 19; Enya Nwocha, *Customary Law, Social Development and Administration of Justice in Nigeria* (2016) 7 *Beijing Law Review* 430; Abdulmumini Oba, *The Administration of Customary Law in a Post-Colonial Nigerian State* (2006) 37 *Cambrian L. Rev* 95; Chinedum Umeche, *Customary Arbitration and the Plea of Estoppel under Nigerian Law* (2009) 35 *Commonwealth Law Bulletin* 291; Neels Claassen, *Mediation as an Alternative Solution to Medical Malpractice Court Claims* (2016) *SAJBL* 7; Nathan Cortez, *A Medical Malpractice Model for Developing Countries* (2011) 4 *Drexel Law Review* 217; Johan Walters, *Mediation – an Alternative to Litigation in Medical Malpractice* (2014) 104 *South African Medical Journal* 1; Khodapanahandeh & Hambali, *Efficiency of Using “Alternative Dispute Resolution” Method in Medical Negligence Claims* (2014) 8 *Advances in Natural and Applied Sciences* 1; Dauer & Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Healthcare Quality Improvement* (1997) *Law and Contemporary Problems* 185; Bismark & McLean, *New Frontiers in Healthcare Mediation* (2006) 9 *ADR Bulletin* 1; Thomas Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice* (1992) *Alaska Law Review* 429; Ashley Davenport, *Forgive and Forget: Recognition of Error and Use of Apology as Preemptive Steps to ADR or Litigation in Medical Malpractice Cases* (2005) 6 *Pepperdine Dispute Resolution Law Journal* 1;

of power between the parties. In the context of healthcare, doctors, not patients, hold most of the power. Doctors are thus likely to drive hard bargains through the ADR process.

One solution would be to have an arbitration system, since this involves private adjudication on the merits of the issue rather than a mediated outcome which reflects the greater power of doctors. In principle, arbitration is therefore preferable but one wonders in practice whether patients, as a group or individually, will be in the position to propose arbitrators who are sympathetic to their situation. It is far more likely that the arbitrators' sympathies will lean more towards their colleagues in another highly prestigious profession.

Mediation is already part of the legal system in Nigeria.<sup>842</sup> It is submitted that the best approach would be for the Model Act to *permit* parties to resolve their disputes, at their option, by alternative dispute resolution methods, including mediation or arbitration, but not to *require* them to do so.

International experience of compulsory mediation is that it is not very successful. To add an extra layer as a compulsory process would not seem desirable.

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<sup>842</sup> Adedoyin Rhodes-Vivour, *Mediation (A "Face Saving Device") – The Nigerian Perspective* (2008) 4 International Bar Association Legal Practice Division Mediation Committee 1, the author (at p 1-2 remarks) that: "Mediation in Nigeria has developed into a more structured process and within a legislative framework. ... Alternative dispute resolution as an alternative to imposed/rights based decisions (eg arbitration and litigation) is encouraged and promoted by our various High Court Laws, the rules of court and the government. Mediation continues to be a tool in Nigeria for the resolution of disputes in an amicable manner at less cost usually on a win-win basis and with the benefit of face saving." See also Kehinde Aina, *Court Annexed Mediation: Successes, Challenges and Possibilities: Lessons from Africa Session (Nigeria)*, the author in a paper presented at Mandela Institute, Wits School of Law, noted (at p 9) that: "[t]he presiding judge in a matter already undergoing litigation or in the course of a pre-trial conference may in appropriate circumstances refer parties to an MDC. For instance, apart from the High Court of Lagos State, matters may be referred to the LMDC from the Federal High Court or the High Court of other jurisdictions outside Lagos. Also, according to the Rules of Court, every civil suit filed in the High Court of Lagos State is screened for mediation amenability and referred to the multi-door courthouse." [www.conflictdynamics.co.za/.../Mediation-lessons-from-Nigeria-MANDELA-INSTITUTE...](http://www.conflictdynamics.co.za/.../Mediation-lessons-from-Nigeria-MANDELA-INSTITUTE...)

## **Chapter Sixteen**

### **Conclusion: A Proposed Model Medical Negligence Litigation Act for Nigeria**



## *Introduction*

In this Chapter, I present a proposed Model Medical Negligence Litigation Act for Nigeria. My purpose here is to provide in statutory form the substance of how best I consider the law in Nigeria should move forward. Merely expressing a wish that the courts would develop particular doctrines (such as those relating to the standard of professional care, informed consent, causation and proof) is not likely to have any practical effect. A model piece of legislation, however, has some (albeit limited) prospect of leading to change in the medium term. It may possibly provoke focused debate in political fora in Nigeria. A Member of Parliament at either State or Federal level is free to use the Model Legislation as basis for his or her own proposal for reform. The chances in the short to medium term of the Model Legislation being converted into law, at either State or Federal level, are small, but it is not impossible that it will contribute to the debate in a way that facilitates policy analysis by offering textual solutions to the several issues that need to be addressed. It is far easier to debate the merits of a text than amorphous suggestions for change.

## *The Complex Challenge when Proposing a Model Law*

It would be relatively straightforward easy to draft what one might call a "best practice" Medical Negligence Litigation Act, prescribing rights and duties in harmony with the most liberal interpretation possible of key human rights, notably the rights to life, bodily integrity, health, autonomy, liberty and privacy, with maximal endorsement of the right to equality. But such a Model Act would not be the right way to proceed, it is respectfully submitted. Apart from the obvious fact that it would have little or no prospect of being implemented, such a Model Act would simply be wrong for the complex circumstances prevailing in Nigeria. These complexities include (1) cultural diversity; (2) religious differences; (3)

conservative social attitudes which impact on practices and decisions about healthcare; (4) political and economic challenges caused by endemic corruption; and (5), relatedly, limited healthcare resources. Simply wishing these complexities away and proposing legislative strategies that pretend they do not exist does not seem a sensible approach. A law that ignored these realities would not be merely redundant: it would risk worsening the situation by prescribing a set of rules that met with substantial cultural opposition.

#### *The Specific Provisions of the Model Act*

In the following section of this chapter, I elaborate on specific provisions of the Model Act. I explain what they are seeking to achieve; I consider their underlying social policies; and I seek to justify their inclusion.

#### *The Professional Standard of Care*

Earlier in the thesis, I examined how courts in Nigeria and other common law jurisdictions have set the professional standard of care for doctors and other healthcare professionals. That research indicated that courts in every common law jurisdiction have declined to apply a simple test of "reasonable care", which applies in the general run of negligence litigation. They have taken this course for two principal reasons.

First, they are conscious that medicine is a professional discipline, with an ancient ethical tradition going back millennia to Ancient Greece. Doctors have distinctive expertise, requiring significant intellectual depth. Moreover, they have high professional standards, with a self-policing system of ethical propriety. Courts are naturally reluctant to second-guess decisions made by medical professionals.

A second reason for judicial caution is based on the pragmatic concern that too stringent a test could have detrimental effects on the delivery of healthcare. Doctors might engage in "defensive medicine", involving unnecessary and expensive tests and interventions, in order to protect themselves from being sued. Moreover, the relationship between doctor and patient might be rendered more distant, with the doctor regarding the patient as a potential adversary.

Earlier in the thesis, I also described how these entirely legitimate concerns led courts in several jurisdictions, notably Britain, to retain for too long an unduly deferential test, whereby a doctor who adhered to a customary practice in the profession would have a good defence to a claim for professional negligence, regardless of whether the particular customary practice had inherent defects or lacked any rationally defensible foundation. In Britain, it was not until *Bolitho* that this undue deference was abandoned. That step had been taken decades earlier in several other common law jurisdictions. We have seen that courts in Nigeria have shown no clear interest in addressing this question coherently. Their dicta are consistent with openness to embracing the *Bolitho* test but one cannot say with any confidence that such an apparent embrace is based on full regard to the issues at stake.

Accordingly, Section 3 of the Model Act spells out unambiguously that healthcare professionals are to owe patients a duty to take such care as is reasonable in all the circumstances not to injure them and to care for their physical and mental welfare. Section 5 embraces the *Dunne* and *Bolitho* developments by providing that adherence by a healthcare professional with a practice that commands the support of a responsible group of professionals working in the particular category of healthcare concerned is to constitute reasonable care, unless the particular practice

lacks a logical foundation or is otherwise so inherently defective that such defectiveness ought to be apparent to such professional.

It is respectfully submitted that such a test is appropriate for Nigeria. Blind deference to customary practice affords insufficient protection to patients. The test spelt out in Sections 3 and 5 is not unduly onerous for Nigerian healthcare professionals and does not involve difficulties in regard to resource deficiencies, as Section 3 takes account of "all the circumstances (including resource deficiencies)" when determining what constitutes reasonable care.

#### *Deviation from Customary Practice*

What is the best approach to take where a doctor or other healthcare professional deviates from customary practice? The answer depends on a consideration of the circumstances in which such deviation may occur. One type of case is where the doctor concerned deviates through ignorance, incompetence or neglect. In such circumstances, of course, liability should obviously be imposed.

An entirely different category of case is where a doctor is engaging in pioneering medicine, adopting a new approach in order to open up the possibility of a better result. If the courts were to characterise such deviation as inevitably negligent, medical care would fester and never embrace new and better solutions.

The third category is parasitic on the second. Unfortunately, throughout history and throughout the world, there have been medical charlatans, making bold and false promises of cures, frequently for financial gain. They have a ready audience of patients whose condition may already have been diagnosed as fatal, who are tempted to try the "wonder cure". Such charlatans can, of course, be prosecuted and subjected to disciplinary sanctions. Equally clearly, a claim in civil law for negligence should succeed against them.

How, therefore, should the legislation deal with deviation from customary practice? Obviously, it should not characterise deviation inevitably as negligent. But should it take the approach adopted by the Irish Supreme Court in *Dunne*, which is to place the onus of proof on the *patient* to establish that the deviation was negligent? It is respectfully submitted that this would not be the right path for the Nigerian legislation to follow. Deviation from customary practice calls for justification, and the defendant should bear the burden of providing such justification. The innovator, such as Dr. Christian Barnard<sup>843</sup>, should be able to convince the court of the merit of the innovation (subject to stringent requirements of informed consent). Accordingly, Section 6 of the Model Act provides that the failure by a healthcare professional to adhere to any practice commanding the support of responsible professionals working in the particular category of healthcare concerned is to generate the presumption that the healthcare professional has not acted with reasonable care but that such presumption may be rebutted, on the balance of probabilities, by evidence adduced on behalf of the professional.

### *Areas of Expertise*

Courts in every common law jurisdiction have accepted that the standard of care should relate to the particular area of expertise in which the defendant is working. A heart surgeon is to be judged by the standard applicable to heart surgeons; an obstetrician similarly. General practitioners are to be judged by the standard of general practitioners, with all the limits on expertise that this implies by way of contrast with specialists such as heart surgery or obstetrics, but with regard to the distinctive specialisation, that general practitioners may be expected to have.

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<sup>843</sup> On 3 December 1967, he performed the world's first human to human heart transplant at Groote Schuur Hospital, Cape Town, with a gifted cardiothoracic team of thirty people: <http://www.heart-transplant.co.uk/louis.html>

Nurses, as I described earlier in the thesis, have traditionally been excluded from the professional negligence standard as they were regarded by the courts as engaging in work that did not require high intellectual input and that consisted of "following orders" in the sense of executing the practical commands of their "superiors".

As I also described, the trend internationally (including in some African jurisdictions) is to bring nurses within the professional fold, reflecting the way their training has become far more academic in nature than formerly.

The Model Act goes along with this trend. Section 1 defines "healthcare professional" in such a way as to include nurses. Section 4 is sufficiently elastic to enable courts to apply the appropriate professional standard of care to nurses.

### *The Problem of Poor Resources*

Earlier in the thesis, I described in some detail the problem of poor resources, which plagues the healthcare system in Nigeria. This problem extends beyond poor infrastructure and lack of basic equipment, such as X-ray machines, needles and bandages. It includes the "brain drain" of medical personnel who have left Nigeria to take up more lucrative and satisfactory employment abroad, in Europe, North America, Australia, the Middle East and Asia. Courts are faced with a dilemma in attempting to respond to these resource deficiencies. They could hold more or less every public hospital in Nigeria liable for negligence on account of these deficiencies or they could relieve the public hospitals of such liability on the basis that they are doing their reasonable best in the face of these deficiencies, which may be attributable in large part to corruption and poor administration at a high political level. Neither of these solutions is satisfactory. What, therefore, should the solution be? The solution put forward in the Model Act is twofold. First, Section 8 requires the court, in determining whether the management of the care of a patient

has been delivered with due care, for the purposes of paragraph (ii) of Section 7, to have regard to the level of resources available to the institution in question. Thus, inadequate resources may afford a reason for not imposing liability unless, of course, the institution was itself responsible for such inadequacy through its own mismanagement. Secondly, Section 9(1) provides that, where a patient has been injured by the culpable failure at governmental level (whether federal, state or local government) to provide a minimum core of resources to an institution to enable it to discharge its duty under Section 5 in a manner that does not expose patients to an unacceptable risk of injury or loss, the patient shall be entitled to compensation from the governmental agency guilty of such culpable failure.

In determining whether to impose such liability, the court is to exercise its jurisdiction in a manner that is respectful of the separation of powers under the Nigerian Constitution and under international human rights instruments that Nigeria has ratified or incorporated into domestic law.

The idea here is to enable courts to impose civil liability on governmental departments and agencies for egregious neglect of their duty to respect the right to health of Nigerian citizens. Only in cases of failure to provide a minimum core of resources will liability be imposed. This concept echoes the language used by international monitoring bodies in respect of the right to health, recognised by the International Covenant on Economic, Social and Cultural Rights. Subsection (2) of Section 9 is designed to encourage courts to exercise their function under Section (1) in a manner that is respectful of the separation of powers, whilst not denying that the matter is justiciable. South African courts have had to exercise this delicate jurisdiction with prudence and, by and large, have done so very well. With new Constitutions in Kenya and Zimbabwe giving courts a similar role, what has been

regarded as exceptional and a little odd will no doubt, in time, come to be regarded as the norm in the African continent.

### *Non-delegable Duty of Care*

Section 7 of the Model Act establishes a non-delegable duty of care resting on healthcare institutions. This is in accordance with international developments, though questions remain as to whether it is appropriate for institutions entirely operating in the private sphere. It is respectfully submitted that the better approach is to apply the principle to *all* medical institutions. Protecting private institutions from its application would be likely to result in leaving many patients without compensation, in view of the practical problems attaching to insurance cover in Nigeria.

### *Causation, Remoteness of Damage and Proof*

Sections 10 and 15 of the Model Act deal with causation, remoteness of damage and proof. Section 10 addresses causation and remoteness of damage, adopting the test of reasonable foreseeability for remoteness of damage. This is in harmony with the existing law in Nigeria and, indeed, in all common law jurisdictions. As regards causation, Section 11(2) sets out three grounds: the "but for" test, applicable in all common law jurisdictions, the "material contribution" test, which has been part of British law for half a century and is scarcely controversial in Nigeria; and the "loss of chance" test, which is somewhat more controversial but nonetheless seems eminently fair in the context of healthcare in Nigeria.

As regards proof of the claim, Section 15(1) places the onus of proof, on the balance of probabilities, on the plaintiff. Subsection (2) introduces in statutory form the *res ipsa loquitur* doctrine, placing the onus of disproof on the defendant so that a defendant will escape liability only where the defendant can establish, on the



balance of probabilities, either lack of causation or the absence of a breach of duty on the defendant's part. As will have been seen in my discussion of the Nigerian cases on *res ipsa loquitur*, the approach of the Nigerian courts is not entirely consistent but would seem to be at least potentially compatible with what is in Section 15(2).

### *Informed Consent to Treatment*

Earlier in the thesis, I described in considerable detail the developments of the law on informed consent to treatment in common law jurisdictions. I noted its relatively poor articulation thus far in Nigerian jurisprudence and I identified particular cultural and religious challenges that arise in Nigeria, where patient autonomy has not been embraced deeply outside larger urban environments. For good or ill, many Nigerian patients defer to doctors and are troubled by disclosure of risks. Such disclosure tends to make them lose confidence in the competence of the doctors rather than be gratified by the respect afforded to their autonomy. In some communities, matters are compounded by traditional deference to husbands and parents, violative of modern notions of gender equality but no less real on that account.

It would of course be possible to propose a test based on the most liberal versions of patient autonomy, but such an approach would risk leading to unnecessary problems in healthcare, by damaging the trust reposed in medical personnel and encouraging some patients to resort to traditional medicine.

Accordingly, the solution adopted by Section 11 of the Model Act is to prescribe a duty to inform the patient of material risks – in line with developments in Britain, Ireland, Canada, the United States and Australia – but (in Subsection (2)) to require the healthcare professional to be sensitive to cultural context of the plaintiff's life.

No doubt, this is a controversial and somewhat uncertain compromise, but it is respectively submitted that it is better than a potentially damaging prescription of a requirement of disclosure that is in conflict with cultural realities of Nigerian life.

The issue of causation in regard to informed consent has proved problematic in many jurisdictions. The "but for" test of tort law means that, if the patient who has not been properly informed would still have had the treatment had he or she received the proper information, the patient cannot complain that the failure to provide the proper information actually caused the injury that ensued. The decision of the House of Lords in *Chester v Afshar*<sup>844</sup> demonstrates the particular problem arising where a patient, not properly informed, would have had the treatment, *but on a later occasion*.

The solution adopted in Subsections (4) and (5) of Section 11 of the Model Act is to place the burden of proof on the issue of causation on the defendant and to enable the court to award some compensation (subject to a maximum of ₦20,000 (twenty thousand) Naira for breach of the patients right to autonomy in cases where the patient would still have undergone the treatment, either immediately or within a reasonable time thereafter, if he or she had been properly informed of the risk.

### *Contributory Negligence*

The law in relation to contributory negligence seems quite straightforward: careless plaintiffs will have some proportionate reduction made from their compensation to take account of their failure to look after their own interests.

In the context of medical care, however, as I indicated earlier in the thesis, matters are somewhat more complicated. This is especially so in Nigeria, where

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<sup>844</sup> [2005] 1 AC 134.

communication between doctors and patients tends to be poor and where many patients become "non-compliant", not through willfulness but on account of other factors, notably poverty, which can make it impossible for them to purchase expensive medicines or travel long distances to hospital for continuing medical care. Moreover, there is a major problem with illiteracy. Language barriers can also arise.

Section 12 of the Model Act therefore seeks to prescribe a sensible set of rules, designed to require doctors to communicate effectively with their patients so as to ensure that they fully understand what they are meant to do and to require courts to have full regard to the economic and social factors that may make it impossible for a patient to comply with a treatment regime.

### *Product Liability*

In the chapter on product liability, I discussed the unsuccessful attempt by a litigant in South Africa to convince the Supreme Court of Appeal that the patient's constitutional right to bodily integrity required the introduction of a strict product liability regime. The Court declined to do so, not because it thought this a bad idea, but rather because it considered it a matter that the legislature should address. The Model Act, in Section 13, does precisely this. It introduces a strict liability regime for medical products, generally on the lines of the European Product Liability Directive<sup>845</sup>.

An important difference from the Directive is that "producer" in Section 13 is defined as including "a hospital or other healthcare institution that requires the

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<sup>845</sup> 1985 (85/374/EEC).

patient concerned to purchase the product concerned as part of the hospital's delivery of its duty under Section 7 to the patient concerned".

This practice, endemic in Nigerian hospitals, cries out for the imposition of strict liability in order to restore the proper balance between hospital and patient.

### *Limitation of Actions*

Earlier in the thesis, I discussed the role of limitation of actions in medical negligence litigation. It is essential that the Statute of Limitations should be suspended until a patient could reasonably become aware that he or she had right of action against the medical healthcare professional or institution concerned. It would not be wise to follow the legislative precedent of Ireland on this matter which risks defeating a claim where the patient was aware of facts without any chance of appreciating their legal significance. The Irish courts in recent cases appear to have benevolently misconstrued the 1991 legislation<sup>846</sup>. The Model Act, in Section 14, avoids this difficulty.

### *Wrongful Birth Claims*

Earlier in the thesis, I examined the differing approaches throughout the world to this troubling area of the law. The solution adopted in Section 16 of the Model Act is to give the mother the entitlement to sue for compensation for negligence resulting in the birth of a child but to restrict the claim to compensation for the injury and loss she sustains in respect of the pregnancy, labour and birth process. There are, of course, strong arguments for going further and permitting compensation for child-rearing costs. Whether to go so far is a matter of deep public policy, on which the Model Act takes no position. The generally conservative culture of Nigerian would suggest a cautious approach. For this

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<sup>846</sup> Statute of Limitations (Amendment) Act, 1991

reason, the Model Act does not provide for "wrongful life" claims by children who argue that they would have been better not to have been born, in view of their disabilities or for other reasons. Nigerian culture would not seem sympathetic to such claims and I consider that the Model Act is more likely to receive positive consideration if it does not include claims of this kind.

### *Expert Panels*

Earlier in the thesis, in my discussion of medical negligence litigation in Nigeria, I recorded how patients find great difficulty in finding experts who are willing to give expert evidence in support of their claim. This "conspiracy of silence" used to be a feature of the litigation process in Ireland, Britain, Canada and Australia.

In order to balance the scales of justice between patient and doctor, Section 17 of the Model Act prescribes the establishment in Nigeria of a panel of experts whose functions shall be to scrutinise possible claims for negligence and to provide expert evidence where it is considered that the particular claim has a prospect of success. A patient who does not convince the panel is not denied the entitlement to proceed with the claim, but such denial would surely act as a disincentive to pursue claims that are not likely to succeed.

The idea underlying Section 17 is to ensure that patients with good claims have a champion in court rather than being defeated by the economic might of the hospital.

The precise workings of this panel system will need considerable discussion as it could be a costly process. The limited volume of medical negligence litigation in Nigeria at present suggests that the costs would not, at least initially, be great.

### *Mediation and Other ADR Strategies*

In Chapter 15, I have outlined the arguments for and against the introduction of mediation and other ADR strategies. I concluded that the best approach is for the legislation to permit, but not require, resort to such strategies. Section 18 so provides.

## **Proposed Model Medical Negligence Litigation Act for Nigeria**

1. This Act shall be entitled the Medical Negligence Litigation Act 2016
2. For the purpose of this Act:
  - "damage" includes injury;
  - "healthcare professional" shall mean any person whose employment includes the provision of healthcare involving specific competencies that require professional training or education in accordance with professional standards of care and ethical responsibility;
  - "injury" includes death.
3. In substitution for any common law liability in tort for negligence, a healthcare professional shall owe a patient a duty of care (hereinafter referred to as a "statutory duty of care") to take such care of the patient as is reasonable in all the circumstances not to injure the patient and to care for the patient's physical and mental welfare.
4. Without prejudice to the generality of section 3, the circumstances to which it refers shall include in particular the following:
  - (i) the nature of the healthcare provided by the defendant;
  - (ii) the level of professional competence required of persons carrying out such healthcare generally.
5. Adherence by a healthcare professional with a practice that commands the support of a responsible group of professionals working in the particular category of healthcare concerned shall constitute reasonable care, unless such practice lacks a logical foundation or is otherwise so inherently defective that such defectiveness ought to be apparent to such healthcare professional.

6. The failure by a healthcare professional to adhere to any practice commanding the support of responsible professionals working in the particular category of healthcare concerned shall generate the presumption that the healthcare professional has not acted with reasonable care but such presumption may be rebutted, on the balance of probabilities, by evidence adduced on behalf of the healthcare professional.
7. A hospital or other healthcare institution shall owe a non-delegable duty to patients:
  - (i) to ensure that all healthcare professionals who have responsibility for the patients' care while the patients are receiving care provided by the institution and who are working for the institution, whether as employees or independent contractors, discharge their statutory duty of care to the patients;
  - (ii) to ensure that the management of the care of the patients is delivered with due care and diligence.
8. In determining whether the management of the care of a patient has been delivered with due care, for the purposes of paragraph (ii) section 7, the court shall have regard to the level of resources available to the institution in question, including (i) physical resources, (ii) medical equipment, (iii) the number and level of professional training of personnel working for the institution, and (iv) economic resources.
9. (1) A patient who has been injured by the culpable failure at governmental level, whether federal, state or local government, to provide a minimum core of resources to an institution to enable it to discharge its duty under section 5 in a manner that does not expose patients to an unacceptable risk of injury or loss shall be entitled to compensation from the governmental ministry or agency guilty of such culpable failure.



- (2) In determining whether to impose liability under subsection (1), the court shall exercise its jurisdiction in a manner that is respectful of the separation of powers under the Nigerian Constitution and is sensitive to the need to vindicate the rights and protect the interests of patients, under the Constitution and under international human rights instruments that Nigeria has ratified or incorporated into domestic law.
10. (1) Where, as the case may be, a healthcare professional or a hospital or other institution breaches a duty prescribed by section 3 or section 7 and the breach causes reasonably foreseeable injury to a patient, the court shall provide compensation for the injury.
- (2) For the purposes of subsection (1), a breach of duty causes injury where:
- (i) but for the said breach of duty, the injury would not have occurred; or
  - (ii) the breach of duty materially contributed to the occurrence of the injury in that it constituted a significant component thereof; or
  - (iii) the breach of duty deprived the patient of a chance of recovery or of other improvement in his or her medical condition that was more likely than not to have occurred in the absence of such breach.
11. (1) A healthcare professional shall owe a duty to a patient to disclose material risks involved in a proposed or contemplated course of treatment.
- (2) For the purposes of subsection (1), "material risks" are risks that a reasonable patient, in the circumstances of the particular patient concerned, would be likely to regard as appropriate to be informed about in the light of their potential gravity and prospect of occurrence.
- (3) A healthcare professional, in determining whether to disclose a risk to a patient and in determining the manner in which to make such disclosure, shall have regard to the circumstances of the particular patient, including his or her age and mental development, his or her capacity to understand and

make a mature assessment of the information that may be conveyed, and the wider cultural context of the patient's life.

(4) Where a healthcare professional breaches the duty prescribed under subsection (1), and a risk that ought to have been disclosed eventuates, causing damage to the patient, liability to compensate the patient for that damage shall be imposed on the healthcare professional unless the healthcare professional can establish, on the balance of probabilities, that the patient would be likely to have undergone the treatment in question, either immediately or within a reasonable time thereafter, having been properly informed of the risk.

(5) In a case where compensation is not awarded by reason of subsection (4), the court shall make a special award, to a maximum of ₦20,000 (twenty thousand) Naira, for breach of the patient's right to have exercised his or her autonomy in respect of his or her healthcare.

12. (1) Healthcare professionals shall be under a duty to take appropriate steps to ensure that patients fully understand what it is necessary for them to do in order to comply with a proposed treatment regime to which they provide their informed consent.

(2) In the discharge of their duty under subsection (1), healthcare professionals shall have regard to the particular circumstances of the patient concerned, including his or her age, mental development, educational level, capacity to read and cultural background.

(3) A patient who suffers damage as a result of the breach of the duty presented by subsection (1) shall be entitled to compensation for such damage.

(4) In determining whether a patient is guilty of contributory negligence by reason of failure to comply with a treatment regime specified by a healthcare

professional in the discharge of his or her duty under subsection (1), the court shall have regard to the circumstances specified in subsection (2), and to the economic circumstances of the patient, including his or her capacity to afford to pay for the medicine or other prescribed treatment.

13. (1) Where a defective medical product causes injury to a patient by reason of a defect, strict liability shall be imposed on the producer.  
(2) A defect shall consist of a failure in the product to provide the level of safety that a patient in all the circumstances would have a right to expect.  
(3) "Producer", for the purposes of subsection (1), shall include (i) a manufacturer of a product, a component part of a product or of a composite product; (ii) an importer of a product into Nigeria; (iii) a hospital or other healthcare institution that requires the patient concerned to purchase the product concerned as part of the hospital's delivery of its duty under section 7 to the patient concerned.  
(4) It shall be a defence that the defect in the product did not exist at the time of manufacture.  
(5) The plaintiff's contributory negligence shall constitute a ground for reduction of compensation in accordance with the provisions of the Law Reform (Torts) Act 1961.
14. (1) No action shall be commenced under section 3, 7, 9 or 13 more than three years after the cause of action arose or, if later, the date when the plaintiff could first reasonably have become aware:
  - (i) that he or she had sustained a significant injury;
  - (ii) that the injury had been caused by the breach of duty concerned;and
  - (iii) that the healthcare professional or institution concerned, as the case may be, had breached his, her or its duty.

15. (1) Subject to subsection (2), a claim made under section 3, 7, 9 or 13 shall succeed if the plaintiff establishes the claim on the balance of probabilities.
- (2) If the plaintiff establishes that he or she sustained an injury when under the care of a healthcare professional or hospital or other healthcare institution, as the case may be, and that injury such as occurred does not normally happen if those providing such care use due care, an onus shall be placed on the defendant to establish, on the balance of probabilities, either (i) that the injury was not caused by any breach of duty under section 3, 7, 9 or 13 or (ii) that there was no breach of duty under section 3, 7, 9, or 13.
16. If a woman gives birth to a child in circumstances where such birth would not have occurred if there had not been a breach of section 3, 7, 9 or 13, as the case may be, she shall be entitled to be compensated for the injury and loss she sustains in respect of the pregnancy, labour and birth process.
17. (1) There shall be established by the State of Nigeria a panel of medical negligence experts, whose functions shall be:
- (i) to scrutinise notifications made to the panel of suspected possible breaches under section 3, 7, 9 or 13, in accordance with criteria and procedural requirements to be specified by statutory instrument;
- (ii) to provide expert evidence to the Court in any claim made under section 3, 7, 9 or 13, where it is determined by the panel that the claim has a reasonable prospect of success.
- (2) Where expert evidence is provided to the Court under subsection (1), it may be subject to cross-examination by any party.

18 (1). The parties to litigation falling within the scope of this legislation may by agreement, before the commencement of the litigation or at any stage

during the proceedings, have recourse to alternative dispute resolution strategies, including, but not limited to: (1) arbitration; and (2) mediation.

(2) During the currency of an alternative strategy, the litigation, if commenced, shall stand suspended.

(3) Either party may terminate an alternative litigation strategy by notice in writing to the other party or parties.

(4) Where such notice in writing has been received by the other party or parties, or, where all parties so agree in writing, the litigation shall thereupon recommence, or commence, as the case may be.

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