NEGLIGENCE AND MALPRACTICE: THE SIAMESE HARBINGERS OF GRIEVE IN CONTEMPORARY NIGERIAN MEDICAL PRACTICE*1

Abstract
Medical practice as indicated by the ancient sages in their wisdom is one of the three noble professions, the other two being legal practice and priesthood (properly so called). In course of the practice of such professions, the relationship between the practitioner and his client/patient is fiduciary in nature, going beyond ordinary contractual relationship. The implication is that the margin for error is minimal. No wonder the sages intoned, particularly for medical practitioners of surgical bent, ‘chirurgusmenteprius, et oculi agat, quam amatamansu’ – the medical practitioner and particularly the surgeon, must have the wisdom of a serpent, the heart of a lion, eyes of an eagle and the fingers of a virgin. He must possess the wisdom to understand what others do not, the courage to be dauntless in spite of all odds, the eyes to see where and what others do not see and the fingers that must, under no circumstances, do no harm to the patient no matter the complexity of the instruments at the disposal of the medical practitioner. The facts therefore speak for themselves that the room for negligence and/or malpractice is as good as nonexistent. In spite of all this, it has been observed, to the chagrin of the healthcare consuming public, that both negligence and malpractice constitute the siamese harbingers of grief to the patients in Nigeria. Unfortunately neither the healthcare practitioners nor the healthcare consuming public have a proper understanding of negligence and malpractice in the medical profession, let alone the inherent and intrinsic dialectico-jurisprudential disparity between the two phenomena. This work has been a humble attempt by the author to elucidate, for the benefit of medico-legal practitioners, the in-built but often unobserved dichotomy between medical negligence and medical malpractice.

Keywords: Medical, Jurisprudential, Malfeasance, Misfeasance, Nonfeasance

1. Introduction
Strict observance of the triad of axioms as postulated by the ancient sages in their wisdom is the hallmark of excellent and rancor-free medical practice. The first axiom states: ‘Omnium disciplinarium medicinan obilissima est’. The implication of this axiom is to the effect that of all disciplines of human endeavour, medical practice stands out as the most noble. Having declared that medical practice is the most noble of the disciplines of human endeavour, the ancient sages further intoned that ‘Qui bene diagnoscit bene curat’ – he who accurately diagnoses would effectively or successfully heal – accurate diagnosis begets successful healing. Furthermore, to justify the fact that medical practice is the most noble profession, the ancient sages left an admonition for all practitioners of the art and science of medicine – ‘primum non nocere’ – by all means do no harm to the patient. It is noteworthy that the sages did not qualify the harm sought to be avoided, thereby leaving medico-jurisprudential scientists and philosophers with the leverage to include all types of harm – physical, emotional, psychological and spiritual. Medical practice therefore, in view of all the foregoing is indeed an extremely serious profession. She leaves no room for errors either of commission or omission. All of that notwithstanding, the practice of medicine today is fraught with all forms of abuses, particularly negligence and malpractice. Unfortunately, probably because of the particularly private nature of medical practice, and the high esteem in which the practitioners are held, the tendency has been to equate negligence to malpractice in the field. Infact many authors in the course of their research have copiously, interchangeably used the two terms. This, of course, is humbly being submitted, runs short of reality and smacks a bit of intellectual lethargy. A thorough scrutiny of both phenomena gives a glaring proof that the two are really not the same, and much as the temptation is very strong to equate one to the other, the approach is faulty.

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2. Medical Negligence

Negligence is an unintentional tort alleged, when one may have performed or failed to perform an act that a reasonable person would or would not have done in similar circumstances. The more common torts within healthcare system are those committed unintentionally. Unintentional torts are acts that are not intended to cause harm, but are committed unreasonably or with disregard for the consequences, thus constituting negligence in legal terms. Negligence is charged when a health care practitioner fails to exercise ordinary care and a patient is injured. The accused may have performed an act or failed to perform an act that a reasonable person, in similar circumstances, would or would not have performed. ‘Did not intend to do it’ or ‘should have known better’ best describe a negligent act. Under principles of negligence, civil liability exists only in cases in which the act is judicially determined to be wrongful. A health care practitioner for example, is not necessarily liable for a poor quality outcome in delivering healthcare. He or she becomes liable only when his or her conduct is determined to be negligent delivery of professional services. It thus becomes crystal clear that, in spite of all axioms and principles of medicine as laid down by the founders and fathers of medicine, most contemporary physicians still fall short of expectations as far as negligence is concerned. The law of tort defines negligence as ‘liability – producing conduct arising from the rendering of professional service’ and since the professional service in question is medical, negligence here could be defined as liability – producing conduct, arising from the rendering of professional medical service. In strict legal analysis as stated by Lord Wright in Local iron and coal company ltd. v Mcmillian, negligence means, ‘More than heedless or careless conduct whether by omission or commission. It connotes a complex notion of duty, breached, and damage thereby suffered by the person to whom the duty was owing.’ In all circumstances of the case, the conduct of the defendant fell short in the given situation of the standard of care within the scope set by law. It was the defendant’s conduct that actually caused the damage, thus for the plaintiff to succeed in negligence he must prove: (a) That the defendant owes him a legal duty to take care (b) That the defendant breached the duty, (c) That the damage, as was reasonably foreseeable, resulted from the breach of such duty to take care.

Equally, negligence as a tort could be viewed to consist of the breach of legal duty to take care, which results in damage undesired by the defendant of the plaintiff. Ordinarily, negligence could be defined as a conduct which falls below the standard established by a law for the protection of others against unreasonable risk or harm. Negligence may be either a mental element which is very technical tort, and which requires strict proof of the element constituting it, or it may connote an independent tort. The importance of negligence as a tortuous liability in Nigeria today is underlined by the fact that since independence majority of cases in torts in this country are in one form of negligence or the other. Most litigation in medical and surgical practice today are as a result of negligence. Professional negligence in the practice of medicine can only be proved on the establishment of the following facts:

i. The existence of the doctor’s duty to the plaintiff, based on the doctor-patient relationship. That is to say, a fiducial relationship must be proved to have been established between the doctor and the patient.

ii. The applicable standard of care and its violation.

iii. A compensable injury

iv. Causal relation or connection between the violation of the standard of care, and the harm or injury complained of.

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2 Karen Judson, Sharon Hicks; Clencoe Law and Ethics for Medical Careers 2nd ed. Glencoe/McGregor – Hill 1999.
3 Ibid
4 Ibid
5 Ibid
6 (1934) A.C.I.
7 WV F Rogers (ed), Jollowice on Tort. (13th edn…) p.72 (London: sweet & Maxwell)22
8 Doctor’s Deadly Errors: Patients’ Tales of woes. The ‘source’ magazine Vol. 30, No 6, Nov.28.2011

Page | 173
There are some variations in the judicial decisions, statutes and the legal literature with the precise scope of the term ‘Negligence’. Some have tried to equate negligence solely with malpractice, as in *Kenny v Piedmont Hospital*. Torts principles have now largely taken the place of the law of contracts as the doctrine that defines professional medical liabilities. Current legal concepts governing the professional negligence of medical practitioners reflects a new awareness of the modern therapeutic potentials of modern medicine, and the heightened public expectation they inspire. However, it must be noted, that provided he has executed reasonable skill and care, a doctor cannot be held in negligence for a mistake in diagnosis. The classic authority for this is Lord Clyde who, when Lord president, stated thus ‘in the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion, and a man clearly is not negligent merely because his conclusion differs from that of the other professional men, nor because he has displayed less skill or knowledge that others should have shown’. Thus it is clear that while an error in clinical judgment need not necessarily be negligence, it can only be so, if it is reached in a manner falling below the test standard, the standard of the ordinary skilled man exercising and professing to have that skill. In the majority of professional negligence, liability will depend on direct evidence of conduct that falls below the level that the society allows, with impunity. Thus the mere fact that a patient suffered a health impairing experience during the course of medical procedure will not, without more, ordinarily render one providing medical service liable for negligence or malpractice.

3. Doctor’s Duty

Duty situations in torts are not confined to negligence alone because there is a general duty cast on persons not to commit any tort at all. However, it is in negligence that the notion of duty is of paramount importance apart from damage. In fact it is the concept of duty that is used by courts as a control mechanism to keep liability for negligence within bounds. Accordingly, for the plaintiff to succeed in an action for negligence he must show that the circumstances from which the damage complained of arose are those capable of giving rise to duty of care. Apart from this, he must also show that such duty was actually owed him by the defendant (i.e duty to act) breach of that duty, compensable damages and proximate cause. There is a duty in the sense and duty infact on the hand, the questions as to whether a circumstance is capable of giving rise to a notion of duty raises questions of law, while on the other hand whether in a circumstance duty is actually owed to a particular plaintiff is a question of mixed fact and law. The question that arises at this point is how are duty situations determined? This may be easily answered where there have been previous decisions. But where there are no precedents the judge is faced with an onerous task. The first attempt at formulating a general principle of duty was by Brelt M.R., in the case of *Heaven v Pender*, when he said ‘whenever one person is by circumstances placed in such a position with regard to another that everyone of ordinary sense recognizes that if he did not show ordinary care and skill in his own conduct with regard to these circumstances, he would host danger of injury to the person or property of the other, a duty arises to use ordinary care and skill to avoid danger.

However, the best and perhaps the most generalization is one by lord Atkin in *Donoghue v. Stevenson* where the principle of neighbourhood was one in question. The rule that you must care for your neighbour becomes in law, you must not injure your neighbour, and the lawyer’s question ‘who is my neighbour’ receives a restricted reply. You must take reasonable care, to avoid acts or omissions, which you can reasonably foresee would be likely to injure your neighbour. Who then, in law, is my neighbour? The answer is, ‘persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question’. In order for one to be held liable for medical surgical negligence, or malpractice, of any sort, it must first be established that the doctor owed a duty of

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9 *Kenny v Piedmont Hospital* 1136 G.A. App 660, 222 S.E 2nd 162 (1975)
12 *Clinkow v Government of Malasia* (1967) WLR813
13 (1983) 11Q3D, 503 & 509
14 (1932) a.c 562
care to the injured party. This duty is one to perform and a concomitant duty to do so as in acceptable manner. The existence of the medical personnel’s duty is based on the legal obligations society on a professional who undertakes to enter into such a relationship.

4. Doctor- Patient Relationship
The express or implied agreement between the doctor and the patient often gives rise to their professional relationship. Therefore, the duty owed by the doctor to the patient is sometimes perceived as being one based on service contract. In most cases, the relationship involves the mutual consent or assent of the parties concerned. Once a doctor – patient relationship is found to exist, the duty of care ordinarily demanded of a health care provider in the relationship is usually imposed by society through its tort laws rather than an incidence of any existing contract between the parties. For this reason the doctor’s duty should be viewed as one broadly on a professional Medical Relationship that may give rise in several contexts and that may give rise to obligation independent of any agreement by the parties. Occasionally however a medical personnel may be sued by a non-patient relationship with someone or from a special contract with the plaintiff.

5. Traditional Professional Relationship
The existence of a doctor-patient relationship is supported by two theories. The first of these theories is the contract theory, where the doctor accepts to render services to a patient in exchange for specific fees. Here, a contractual agreement is created with its attendant rights and responsibilities, where both parties each has a specific agreement, as to the terms of treatment, and an express contract may be said to have been formed. An implied contract may also be created in that the court will infer, from surrounding circumstances such as the consent of the patient, and the link expectation of compensation for the doctor. A contract either expressed or implied is the most common source of patient – doctor relationship. A situation may occasionally arise, which may not conveniently relate to the contractual condition narrated above. This is for instance, a situation where an unconscious patient is treated without his knowledge or express authorization, and by a doctor previously unknown to him. This is common in cases of Road Traffic Accident. Such services are often rendered gratuitously, without any promise or expectation of a fee. It is purely an emergency act, to save life. A more workable theoretical basis that creates a doctor-patient relationship in such cases seems to be offered by a second theory. The theory holds that a doctor who undertakes to render care to another creates a professional relationship with a corresponding duty of care to the patient. Liability may result from substantial care where one undertakes to render service which he should recognize are necessary to protect the safety of another. One who takes charge of another who is helpless would recognize that he may be liable for bodily harm occasioned by his failure to exercise reasonable care to secure others’ safety or by leaving the other in a worse situation or condition or position than before by discontinuing aid or treatment.

The doctor’s duty of care may arise, as a result of an undertaking of treatment, even where the services are gratuitous and not based on a contract, and there is no expectation of payment. It must be noted however, that the mere fact that a doctor is involved in the general practice of medicine or surgery, has not been held sufficient to subject him to respond to the call of any one in need, to aid and moreover, very little in the way of an undertaking may be required to establish a patient-doctor relationship. Where a doctor is assigned to treat a patient specifically an extreme example of doctor-patient relationship, based on undertaking theory arises. In such a situation, the doctor is expected to know the full details of the patient’s illness. In a situation where a patient is brought to the doctor on duty, and he feels that the condition is not serious, and patient therefore asked to go home till the next morning, if the patient subsequently dies the court would hold inter alia that there was a breach of duty on the part of the doctor. But as in the case of Gallanzav Sands\(^\text{15}\), where at no time had the physicians met the patient, examined her, diagnosed her condition or had any contract with the patient or her family, the court would hold that a notable issue of fact existed, that no physician-patient relationship was created. In hospital cases, courts have been even willing to find it necessary to support the creation of Hospital-patient relationship. Where there was a mere gratuitous promise to render services, the general rule has been to

\(^{15}\) 316S. 2d77 (fla App. 1975)
impose no tort liability on the promisor for non-performance, even though the promisee relied on the promisor to his detriment. A promise by a patient or a third party to pay for future services promised by a doctor should certainly be adequate consideration to support a contract, which in turn would create a duty. In addition, when the doctor’s promise is made in a setting that would suggest an implied agreement to perform services in exchange for a fee, the courts seem to assume that a duty is created.

In Maltempo v Curthbert\(^\text{16}\), a physician promised to parents to look into the deteriorating condition of their diabetic son who was imprisoned, apparently creating a duty. Although there was no evidence that the physician had undertaken to perform by calling the jail or prison, the court did not rely on that as a bases of duty but rather held that the parents had a right to rely on the physicians assurances. The courts have through the implied contract and undertaking theories, broadened the class of activities that may give rise to a physical/surgeon-patient relationship. Nevertheless, there are limits to their willingness to find existence of such relationship. In a decided case, a patient sued a medical school professor, who at a professional conference offered an opinion that surgery was indicated after hearing the patient’s history. In upholding the dismissal of malpractice case, the Appellate court held that there had been no physician-patient relationship between the professor and the patient. The general test adopted by the court for deciding whether a duty existed in the absence of traditional doctor-patient Relationship involved a balancing of such factors as the extent to which the defendants action were intended to affect the patient the foreseeability of harm, the certainty of the patient’s injury, the closeness of the condition between the defendants conduct and the injury, the closeness of the condition between the defendants conduct and the injury suffered, the blame-worthiness of the defendant’s conduct, the policy of preventing future harm, the kind of person with whom the defendant was dealing the relative ability of the parties to adapt practical means of preventing injury, defendant, the court noted that he had no right to control the patient’s treating physicians, and that the imposition of liability might tilt effort aimed at disseminating medical knowledge as in the case of Rainer v Grossman\(^\text{17}\). The cases like that of Rainer are often dealt from a number of analytical perspectives. Some courts focus on questions of relationship and duty, while others seem to or rely upon the traditional doctrine of proximate cause.

6. Professional Relationship: Its Limitation and Temptation

Doctor-patient relationship is normally based or mutual relationship between the doctor and the patient. It therefore follows that the doctor (within the bounds permitted by public policy) is usually free to limit the scope of that relationship. A practitioner is at liberty to limit his office hours or consultation hours, and may adopt policies limiting or excluding house calls, at least in the absence of reasonable expectations of the patient to the contrary, or emergency. A doctor may also choose to limit or restrict the nature of his practice by specializing, and where consistent with sound medical practice, by refusing to perform certain types of medical or surgical procedures. It must be noted that unless such limitations are reasonably to be expected based upon common practice, or upon prior course of conduct of the doctor, a doctor should notify the patient in advance, of significant limitations on his practice. Should be patients’ condition call for surgical procedure, and the surgeon does not choose to perform; he has an obligation to refer the patient to another doctor for necessary treatment. Implied limitations are often also found in professional relationship. Although the doctor may refuse to enter into a professional relationship with the patient, and may at the outset normally limit the scope of his professional involvement in a relationship, he does not otherwise have an unqualified right to terminate an existing relationship. The effect of the above is that unless by an express or implied understanding of the parties, the relationship cannot be terminated at the will of the doctor unless treatment is no longer required, the relationship is terminated by the patient, or suitable notice is giving that affords the patient a reasonable opportunity to engage the services of another doctor. The patients’ condition, the availability of another competent doctor the manner of the notice, and the patients’ educational status are among the factors that determine the reasonableness

\(^{16}\)504F.2d 325 (5th Cir 1974)
\(^{17}\)31 cal. App.3d 539, 107 Cal. Rptr. 469 (1973)
of the notice, as was determined in the case of Grace v Meyers\(^{18}\). Provided a reasonable opportunity is afforded the patient to obtain another attending doctor, or the patient dispenses personally with the services of the doctor, the doctor is theoretically free to withdraw from a case. In circumstances where treatment is already scheduled and the condition stipulated above are not met, the doctor is liable on conviction to pay damages for breach of contract. Where statutes providing for voluntary arbitration of malpractice disputes state that the patience agreement to submit to arbitration is not a prerequisite to treatment, because such statutory provisions may suggest a potential limitation on the right of the doctor to refuse to enter into a doctor patient relationship, or to terminate an existing relationship, where the relationship is unilaterally terminated, prematurely terminated, or disregarded by the doctor without reasonable notice, the doctor is liable for abandonment of the plaintiff (patient) as in the case of Baulsir v Sugar.\(^{19}\)

The proof of abandonment is not as rigorous as in malpractice. It is common in practice that the courts tend to lump together situations involving negligent failure to diligently follow a patient with the traditional intentional abandonment cases. All the same, there is a distinction between negligence and abandonment. This distinction manifests in the fact that the negligence, expert testimony as to standard of care is required, while in intentional abandonment, the mere fact of termination may establish the defendants fault. Sometimes a patient may fail to pay, or may refuse to co-operate in treatment. Such action may not relieve a doctor who without reasonable notice abandons or negligently fails to attend to a patient. Above situation is particularly true when the patient’s conduct does not become so obstinate as to defeat the efficacy of the treatment, or constitute a withholding of consent of treatment. Notice should be taken of the fact that the selection of a competent substitute doctor to care for the patient may not prevent liability for abandonment, particularly if damages proximately result therein, and it is proved that notice was not given in sufficient time to enable the patient to engage a doctor of choice. This was the case in Miller v Dore\(^{20}\), where a patient decided to postpone surgery until the return of her original physician. Referral from one doctor to another competent or specialized doctor is a common, allowed, and indeed laudable occurrence in surgical practice. Therefore, where a patient is referred by one doctor to another competent doctor, there will generally be no liability where the patient’s condition reasonably appears to warrant such a referral, and the patient is duly informed. This is particularly safe, when it is the considered professional opinion of doctor that the patient will be benefit more from such a referral.

7. Res Ipsa Loquitur

The doctrine of res ipsa loquitur is applicable in the cases where there is prima facie evidence of negligence, the precise cause of the incident cannot be shown, but it is more probable than not that an act or omission of the defendant caused it and that the act or omission arose from a failure to take proper care for the plaintiff’s safety. The doctrine has been frequently invoked in Nigeria courts and has attracted more judicial comment than almost any other aspect of the tort of negligence.\(^{21}\) The most well known definition of res ipsa loquitur is that propounded by Eric C.J in Scott v London and St. Katherine’s Docks Co.\(^{22}\) Res ipsa loquitur simply means that ‘the thing speaks for itself’. In other words, although direct evidence of precisely how the injury occurred is lacking, the nature of the injury itself may so strongly suggest wrongful conduct that nothing more is necessary to present at least a prima facie case strong enough to allow the plaintiff to reach the injury. Therefore, the courts may draw an inference of negligence or cases in which the plaintiff proves that an accident has occurred, but is unable to show or say how it all happened. In such a situation, if strict rules of evidence are applied, the plaintiff may fail in his action for want of sufficient evidence of negligence. It is thus a rule of evidence which applies where the facts are so clear as to provoke a presumption of negligence on the part of the defendant, and require him to explain to the court’s satisfaction that the accident was not due to want of reasonable care on his part. The

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\(^{18}\) 224 N.C165, 295, E 2d 553 (1994)
\(^{19}\) 266 Md. 390, 293A 2d 253 (1973)
\(^{20}\) 154Me 363, 148A 2d 692 (1959)
\(^{21}\) Igbokwev University Collage Hospital Management Board.
\(^{22}\) (1865) 159 E.R 665
Supreme Court, in the cases of Management Enterprises v Otusanya\textsuperscript{23} held that ‘res ipsa loquitur’ is applicable to actions for injury by negligence, where no proof of such negligence is required beyond the accident itself, which in such a case, necessarily involves negligence. The case of Folorum v Akanma\textsuperscript{24} is also one of such cases where the doctrine of res ipsa loquitur was used.

### Elements of Res Ipsi Loquitur and Application to Medical Practice

There are three elements that generally must be satisfied in order for the doctrine of res ipsa loquitur to apply. There are:

1. The event must be of a kind, which ordinarily does not occur in the absence of someone’s negligence.
2. It must be caused by an agency or instrumentality within the exclusive control of the defendant.
3. It must not have been due to any voluntary action or contribution on the part of the plaintiff.

It is noteworthy that the judicial response to the doctrine of res Loquitur in the medical setting has been ambivalent. The patient has entrusted his safety and wellbeing in to the hand of the doctor. He is often unconscious or otherwise incapable of fully knowing what caused his injury. Due to his lack of medical training, he does not normally understand the medical complexities of his injury. The doctor is in a better position than the patient to explain how the injury occurred. Thus when something goes wrong, and no one either can, or is willing to explain, there is a natural tendency to conclude that the doctor or hospital should bear the loss.

A good example is cases where medical instrument are ‘forgotten’ in the patients’ body, or the wrong organs are mistakenly removed while the diseased organs are left intact. It should be noted that a doctor does not impliedly guarantee the success or otherwise incapable of fully knowing what caused his injury. Due to his lack of medical training, he does not normally understand the medical complexities of his injury. The doctor is in a better position than the patient to explain how the injury occurred. Thus when something goes wrong, and no one either can, or is willing to explain, there is a natural tendency to conclude that the doctor or hospital should bear the loss.

The doctrine of res ipsa Loquitur sometimes threatens to impose malpractice liability for such innocent but unexplained occurrences. Indeed, the doctrine has occasionally been equated with strict liability as in the case of CLARK V. GIBBONS\textsuperscript{25}. The weight of authority holds that res ipsa Loquitur is applicable at least in some factual settings in medical practice controversies\textsuperscript{26}.

### 8. Examples of Negligence In Nigeria

On October 9, 2012 Laure Amoo - Onidundu was shot in the leg by armed robbers. He was rushed to Gbagada General Hospital. On arrival to the hospital, he was told that there was no free bed, so he was ‘admitted’ to the bare floor of the emergency section of the hospital – a government hospital. He lay on the floor bleeding for hours, without receiving any treatment or even basic first aid. After several hours he was eventually placed on a gurney and a medical doctor examined him there in the emergency room. The doctor felt the area around the gunshot wound to see if there were any bullets or fragments in the leg. There he gave Amoo an injection to help relieve his pain, and lacking any proper dressing, wrapped the wounded leg with brown carton paper. They eventually extracted the bullet which was lodged in his thigh slightly above the knee, and sutured him up! The medical staff did not examine his injury with a CT scanner or a common X-ray, or any other imaging technology to verify the extent of the damage. Amoo remained in the hospital for days receiving no further treatment, other than the usual daily dressing. The condition of his leg deteriorated. On October 25, sixteen days after he was admitted to the general hospital, Amoo was moved to a private hospital by his relations. Here a CT scan confirmed that the bullet had pierced his right thigh just above the knee. The scan also showed that the bullet had broken the thigh bone and severed the main femoral artery, cutting off the blood supply to the lower part of the leg. The doctors at the first hospital (the general hospital) would have seen this had they ordered a CT scan, and

\textsuperscript{23}(1987) 4SCNJ 100 at 123 - 124
\textsuperscript{24}(1980) 2 D.A C 162
\textsuperscript{25}66Cal. 2d 399, 416, 58, Cal. Rptr. 125, 137, 426p, 2d525, 537 (1967)
\textsuperscript{26}Igbokev.U.C. H >Mgt Board Supra.
would have had a fighting chance to save the leg. Moreover, the wound was infected, so the leg had to be amputated. Today Amoo lives with a prosthetic limb, a constant reminder of medical negligence every day

In a second case, Mrs. Juwura on June 7, 2001 had entered the maternity ward of the University College Hospital, to be delivered of her second baby by elective caesarian section after having suffered complications during her prior delivery. She was wheeled into the operation theatre about 9.00 am and the baby was brought out of the theatre at about noon. The average caesarian section takes about 45 minutes, but Juwura’s case was not average her left fallopian tube had been punctured and subsequently removed during the procedure. After the operation, Juwura’s PCV (Packed Cell Volume) dropped significantly, indicating severe blood loss. She was given a blood transfusion, but instead of stabilizing, her PCV kept dropping. A normal PCV ranges from 34 to 38, Juwura’s plummeted from 37 before surgery to 22 after surgery. Even after the transfusion, her PCV fell to 20, then to 17. Finally she went into shock. She had been transfused with the wrong blood type. Juwura died on June 8, 2011, leaving behind her newborn baby, her two-year-old child and her husband.

Episodes of medical negligence are innumerable in Nigerian. Unfortunately, due to ignorance, and negative fatalism, most, if not all of the episodes are attributed to the act of God.

9. Malpractice
Malpractice, which derives from the expression, ‘Mala praxis,’ is a phenomenon of a decidedly wider scope than negligence. It encompasses a large number of unworthy practices in medical, nursing, pharmaceutical and other endeavours. Negligence is a constituent part of malpractice. Black’s Law Dictionary defines malpractice generally as ‘unskillful treatments…injuries, affecting a man’s health, are where by any unworthy practices of another, man sustains any apparent damage in his vigour or constitution, as by selling him bad provisions or wine…or by the neglect or unskillful management of his physician, surgeon or apothecary. ‘For it hath been solemnly resolved…that mala praxis is a great misdemeanor, and offence at common law, whether it be for curiosity and experiment, or by neglect, because it breaks the trust which the party had placed in his physician, and tends to the patients destruction’. The same Black’s Law Dictionary specifically defines medical malpractice as ‘A doctor’s failure to exercise the degree of care and skill that a physician or surgeon the same medical specialty would use under similar circumstances’. Dada in his book ‘Legal Aspects of Medical Practice in Nigeria’ hinted at the disparity between negligence and malpractice when he stated ‘….negligence used to be referred to as ‘malpractice’ though this is not strictly synonymous, as other forms of irregular medical practice may be malpractice…..’ One of the most expansive definitions of malpractice, was proffered by Umerah thus: …five common pitfalls constitute malpractice

1. Adultery with a patient with whom the doctor has a professional relationship…..
2. Advertising or canvassing for patients
3. Illegal acts such as harbouring or treating in secret, criminals, wounded armed robbers, who are fugitives from the law, performance of illegal abortions.
4. Treating or performing an operation under the influence of alcohol or drugs may result not only in civil but also in criminal negligence.
5. Addition – Abuse of dangerous drugs or the privileges.

To avoid liability, the practitioner must ensure that behaviour to the patient is proper and that treatment whether in the form of surgical – medical management or investigative procedures are carried out in a manner that conforms with accepted standards and norms’. The American definition of malpractice is most apt, and thought-provoking. The definition and subsequent classification is based on ‘feasances’. According to American

29 ibid
definition, because the term malpractice refers to just one area of medical liability and implies bad or dishonourable behaviour, the term preferred by most health care practitioners is medical professional liability. According to them, all medical professional liability claims are classified in one of three ways, based upon the root word ‘feasance’, which means ‘the performance at an act’.

(a) Malfeasance: Is the performance of a totally wrongful and unlawful act. For example, in the absence of the employing physician, a medical assistant determines that a patient needs a prescription drug and dispenses the wrong drug from the physician’s supply. Medical assistants are not licensed to practice medicine, and the wrong drug was dispensed. The act was totally wrongful and unlawful and could be called malfeasance.

(b) Misfeasance: This is the performance of a lawful act in an illegal or improper manner. Suppose a nurse is ordered by his or her employing physician to change a sterile dressing in a patient’s burned hand. The nurse changes the dressing, but does not use sterile techniques, and the patient’s burn becomes infected. The nurse legally authorized to carry out the physician’s instruction in dressing the patient’s hand, but violated proper procedure in carrying out the physicians order.

(c) Nonfeasance: The failure to act when one should for example. Suppose a newly certified emergency medical technician is first upon the scene of a traffic accident. An injured motorist stops breathing and appears to be in cardiac arrest.

The emergency medical Techniques though trained in cardiopulmonary resuscitation ‘freezes’ and does nothing. The patient dies. In failing to act, the EMT could be guilty of nonfeasance.

Laudable as the American expose on medical malpractice may seem, its attempt (or lack of it), at the differentiation between medical malpractice and medical negligence is at the best, nebulous. A good number of Nigerian scholars of the medico-jurisprudential studies seem to recognize the intrinsic dialectico-jurisprudential dichotomy between medical malpractice and medical negligence, thereby insinuating and correctly so, that medical negligence is a constituent part of medical malpractice, which is indeed a wider phenomenon. Thus, Dada enthused that ‘… Historically, it (medical negligence) used to be referred to as medical malpractice…, though this is not strictly synonymous, as other forms of irregular medical practice may be malpractice, not sounding negligence’. Other scholars constantly and interchangeably use medical malpractice and medical negligence, thereby occasioning the impression that both are the same, or that one is the synonym of the other. Such scholars include Emiri, who indicates that ‘…medical errors or negligence’. He further states that ‘…medical malpractice operates on two basic principles (i) patient consents to treatment, and (ii) treatment undertaken without proper care and skill’. This creates the impression that medical malpractice and medical negligence are dialectically equivalent or coterminous. His further asserted that ‘…medical malpractice is the failure by a medical man to exercise reasonable degree of skill and care. The failure to exercise the standard of care that a reasonable man should exercise in a given circumstance further tends to buttress the afore mentioned assertion. This author, a product of many years of medico-legal practice and research, humbly seeks to opine that much as medical malpractice and medical negligence might be intricately, complicatedly interrelated and interconnected, they are neither co-terminous, nor is one the synonym of the other. They are dialectically and jurisprudentially one different from the other. At the best, the relationship between medical malpractice and medical negligence is jurisprudentially akin to that between law and mortality. Such a relationship is metaphorically visualized by that between two intersecting circles. The part inside the intersection represents the common ground between the two

34 Ibid
36 Ibid
39 Ibid
40 Ibid
phenomena, while the parts outside the intersection represent the district realms in which each of them holds exclusive and absolute sway.

One of the areas in which malpractice could hold a distinctively absolute sway is in the realms of consent to consultation and physical examination by the healthcare practitioner. Consent to consultation and physical examination could be either express or implied. Consent may be taken to be implied when the patient presents himself or herself for treatment or examination. Even so, the implication only pertains to what the patient would reasonably expect, as any other thing could amount to malpractice. For example, a patient does not expect a vaginal or rectal examination when the presenting complaints such as cough, catarrh, and sore throat show no medical indications for such examinations. Sometimes, a dedicated doctor might contend that a full examination of the patient is necessary for accurate diagnosis. In that case, the doctor should exhaustively explain same to the patient, and obtain specific consent of unusual clinical methods, and it is well to have the consent given in the presence of a witness. Anything on the contrary, would render the doctor liable in malpractice.

Examination of patients, particularly patients of the opposite sex should ideally always be chaperoned i.e carried out in the presence of a third party. Unfortunately, the current shortage of nursing staff, the nonchalant attitude of some medical doctors, and high degree of illiteracy in the country (which in turn makes most patients oblivious of their basic rights) make this a counsel of perfection which it is almost impossible to observe. Be that as it may, the situation does not exonerate or shield the medical doctor or examiner from liability for malpractice. Circumstances also abound particularly in the practice of obstetrics and Gynecology where female clients are subjected to elective caesarian section even in the absence of Cephalo-Pelvic Disproportion or any medical indication for caesarian section, reasons for the operation being increase in revenue generation. In such a situation there is no medical negligence since the duty of care owned the patient is properly discharged and no legal injuries ensued. But obviously, the medical Doctor for reasons of financial benefits has indulged in malpractice and therefore stands liable. Furthermore, itchy-fingered surgeons have been known to perform appendectomy for simple appendicular irritation or peri-appendicular irritation, out of share intellectual lethargy, which inhibits proper differential diagnosis. Of course in such a situation, the duty of care owed the patient is effectively carried out without legal injuries but medical malpractice has been occasioned. Same applies to unwarranted cases of tonsillectomies where conservative management would have sufficed.

10. Conclusion
Many scholars of the medico-legal discipline in their day-to-day endeavours have often erroneously equated medical malpractice to medical negligence. Nothing could be further from the reality. Granted, superficially speaking, medical malpractice and medical negligence would appear to be identical. However, an analysis of greater profundity would elucidate the fact that there is a dialectico-jurisprudential disparity between the two phenomena. Similar as they may seem, the relationship between medical malpractice and medical negligence is indeed best defined as being akin to that between two intersecting circles, in which the area within the intersection represents the common grounds between the two, while the parts outside the intersection represent the distinct realms where each of them holds exclusive, absolute sway.

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