A CASE FOR ENHANCED PATIENT'S WELFARE LEGISLATION IN NIGERIA

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1. Abstract

The corpus of the law regulating the right of the patients and the duties of medical practitioners and other health care providers in doctor/patient relationship is essentially common law. In our clime where even the educated members of the society are not aware or are lukewarm about their medical rights, it becomes a clear necessity that such laws should be codified in order to ensure certainty, accessibility and a sort of enlightenment on the extant medical rights to the citizenry. Also the average Nigerian patient is an indigent one. Cases abound where patients are treated and discharged but cannot go home due to the lack of wherewithal to discharge the burden of the medical bills. Such patients can only be said to be imprisoned by their economic woes, accentuated by lack of care and attention of the government and policy makers. In this peace, the position is taken that some pragmatic legislative reforms will not only achieve the above benefits to patients but also further assuage their burden as "patients" and thus enhance welfare intervention of the state in their favour.

2. Introduction

The law and practice of Medical Law and Ethics is still essentially regulated by common law. This truism is even more relevant to the law that regulate the rights of a patients including the right of access to health facilities, informed consent

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before treatment, confidentiality, accept or reject treatment, emergency treatment, referral, among others. The effect is that since the greater percentage of the people, and by extension, patients are not learned in law, most Nigerians are ignorant of their medical rights. This is irrespective of whether such people are educated or not.

The proposition here is that the widespread ignorance of medical rights by Nigerians (both educated and uneducated alike) is, to some extent, encouraged by lack of a comprehensive legislation that regulates the healthcare delivery system, particularly, the medical rights of the people. For instance, due to the fact that obtaining property by false pretence is enacted as section 419 of the Criminal Code, almost every adult Nigerian is aware that the law prohibited such act as people perceived to be engaged in such acts are generally referred to by literates and illiterates alike as "419ers". In order words, the section of the law creating the offence has helped in publicizing the prohibition of obtaining property by false pretence. By the same token, it is hereby canvassed that an Act of National Assembly or State House of Assembly setting out the Patient's Bill of Rights and criminalizing breach of patients' medical rights may gain popularity among all and sundry by the very fact of its codification.

3. Previous Codification Efforts at Protecting Patients Rights

Previous attempts at setting out the rights of patients in a code have not achieved any level of education for the members of the public nor ensured proper protection of their rights let alone making welfare provisions in favour of the patients. This is because such efforts concentrated mainly at codifying the liabilities of medical practitioners. Such laws include:

3.1 The Declaration of Lisbon, 1981

The Declaration of Lisbon, 1981 is a code of the rights of patients adopted by the 34th World Medical Assembly, Lisbon, Portugal between September and October, 1981. The declaration set out the following rights of the patients:

a. The patient has the right to choose his physician freely;

b. The patient has the right to be cared for by a physician who is free to make clinical and ethical judgments without any outside interference;

c. The patient has the right to accept or to refuse treatment after receiving adequate information;

d. The patient has the right to expect that his physician will respect the confidential nature of all his medical and personal details,

e. The patient has the right to die in dignity; and

f. The patient has the right to receive or to decline spiritual and moral comfort including the help of a minister of an appropriate religion.

3.2 Medical and Dental Practitioners Act.

The Medical and Dental Practitioners Act[3] is the basic legislation for the regulation of medical practice in Nigeria. It is only tangentially related to the right or welfare of patients in Nigeria.

Section 1 of the Act sets up the Medical and Dental Council of Nigeria as a body corporate with perpetual succession and a common seal which may sue or be sued in its corporate name. The functions of the Council may be summarized as follows:

1. Regulation of standard of medical education in Nigeria;
2. Registration of medical practitioners and dental surgeons and establishment and maintenance of the register of medical practitioners and dental surgeons;
3. Discipline of medical practitioners and dental surgeons;

[3] Cap M8, Law of Federation of Nigeria 2004

4. Supervising and controlling the practice of alternative medicine; and
5. Regulation of clinical laboratory in the field of pathology.

From the above, it is clear that even though the right and welfare of the patients may be indirectly protected by the Act ensuring proper regulation of practice and discipline of practitioners, it cannot be said to be a law set out to codify the rights of the patient, nor to assuage the special welfare needs of the patients.

3.3 Code of Medical Ethics in Nigeria.

The other document that makes provision for the rights of patients is the Code of Medical Ethics in Nigeria.[4] This Code governs the practice of medicine in Nigeria by the medical and dental practitioners. As such it is a code that is restricted in application, publicity and distribution. Besides, the offences under the code are not subject to trial or claim in the regular courts but under the jurisdiction of the

[4] This code was made by the Medical and Dental Council of Nigeria pursuant to its powers under section 1(2) © of the Medical and Dental practitioners Act, Cap M. 8 Laws of Federation of Nigeria, 2004

Medical and Dental Practitioners Disciplinary Tribunal set up under section 16 of the Act.[5]

Thus, while the Declaration of Lisbon, 1981 is only an international appeal by the World Medical Assembly on the rights of patients to be respected by doctors in their practice, the Code of Medical Ethics in Nigeria does not meet the biting and coercive requirement of a patients Bill of Rights. As such there is an urgent need for a clear-cut legislation at both national and state levels that would set out the patients' Bill of Rights. The publicity of the Bill by NGOs, CSOs, public hearing in the national and state Assemblies, gazetting in Federal and State gazettes, etc would readily be a source of public education on the existence of patients right to adequate and competent medical care and the corollary right to make claims against any medical practitioner that breaches the right.

3.4 The National Health Act, 2014

The new National Health Act signed into law by the president in November, 2014 appears to have made some progress in codifying patients right if signed into Law. The Act defines a "User" of a health service or facility in terms of a patient to mean "the person receiving treatment in a health establishment including receiving

[5] Medical and Dental Practitioners Act.

blood or blood products or using a health services".[6] If the person is below the age of majority, "user" includes the person's parents or guardian or another person authorized by law to act on his behalf. Where the user is incapable of taking decision, the term includes the person's spouse or in the absence of such spouse, the person's parent, grandparent, adult child or a person authorized by law to act on his behalf.[4]

The Act makes the following provisions on the rights of the user:

a. Right of access to any public health establishment for the purpose of receiving health services,[7]

b. Right of referral where the health establishment is not capable of providing the necessary treatment or care;[8]

c. Right to receive emergency medical treatment,[9]

d. Right to receive relevant information pertaining to his state of health and necessary treatment relating thereto including:

[6] Section 67 of the Act
[7] Section 17(1) of the Act
[8] Section 17(2)
[9] Section 20

- The user's health status except in circumstances where there is a substantial advance evidence that the disclosure of the user's health status would be contrary to the best interest of the user;

- The range of diagnostic procedures and treatment options generally available to the user;

- The benefits, risks, costs and consequences generally associated with each options; and

- The user's right to refuse health services and explain the implications risks and obligations of such refusal[10]

e. The right to confidentiality of information relating to his or her health status, treatment or stay in a health establishment[11], and

f. Right to lay complaint about the manner in which he or she was treated at a health establishment and to have the complaint investigated[12].

Much as it is appreciated that the Act represents a tremendous advancement in the codification of the right of the patients, it only achieved a list of rights without a

[10] Section 23
[11] Section 26
[12] Section 30

corresponding list of offences and punishment for the breach of these rights. Thus, apart from the right to receive emergency medical treatment the breach of which attracts a fine of N100,000 or imprisonment for a period not exceeding six months, no other penal provision is made in the Act for breach of patients' rights. The patients are left to fall back on the general criminal prohibitions for punishment and general law of tort for claims. Accordingly, the Act still shrouds the right of patients to medical malpractice claims in the same maze of common law.

It is strongly advocated that a specific and comprehensive legislation on the patient's Bill of Rights is a clear necessity in Nigeria in order to enhance the knowledge of Nigerians of their medical rights and consequent rights to claim accordingly against erring medical practitioners.

4.0 Proposal for Welfare Legislation for Patients.

4.1 Introduction of Patients Compensation Scheme and Liability Insurance

A common trend established by investigation in this research is that medical malpractice claim is a costly adventure which is out of the reach of the poor in the society.[13] Also, the technicality and the battlefield-posture of the parties in proving

[13] 66.9% of our respondents strongly agreed that poverty is the cause of low level of medical malpractice claims in Nigeria while another 21.84% simply agreed giving a total of 88.83%.

and defending cases all too often make litigation unpredictable both in outcome and time of completion. The high cost of litigation in time and money is generally attributable to the traditional requirement in proving damage in tort which requires that the plaintiff must establish a causal connection between the act or omission of the defendant with the injury or damage suffered by him. Giesen succinctly captured the underlying factors behind cost and delay in medical malpractice litigation in the following words:

> Despite praiseworthy efforts in trimming down time consuming and costly litigation, the essence of the problem lies of course, in the basic principle of our traditional damage actions: a successful claim depends upon proving causation and negligence on the part of the defendant hospital or physician who are quite often 'judgment proof' forcing the parties into adversarial positions even where no adversarial system does exist.[14]

The effect of the present litigation system, especially in medical malpractice claims is that the State abandons the citizen who is in need of immediate attention and help to fend for himself by insisting that he can only be compensated if he shows that the damage or injury arose out of no fault of his. But, this is certainly antithetical to the growing demand of welfarist States to intervene in the suffering

[14] Giesen, *OP. Cite*. pp 529-530.

of their citizens by the simple reason of citizenship. Such welfarist attitude therefore requires a paradigm shift from the fault-related to loss-related compensation scheme to the effect that once a loss, damage or injury is proved, compensation attaches without the need to prove that the doctor, hospital or the health care system is responsible for the loss, damage or injury as the case may be.

Accordingly, and as has been aptly suggested:

> It must become the concern of public policy and law reform to help those who fall victim to the chain of events following a medical mishap, by shifting from cause-related to loss-related compensation and eliminating the fault element of the present tort (and delict) system. … What is required in the first place is the realization that the social waste and unhappiness caused by all serious personal accidents ought so far as possible to be made good, and not only in the case in which someone other than the victim was to blame.[15]

Although, a no-fault compensation scheme for victims of healthcare mishap had been suggested as far back as 1951 by Professor Albert A. Ehrenzueig,[16] it was only until recently that such scheme firmly took root in some developed countries. The law in New Zealand, Sweden and Germany are briefly examined below as a case study.

[15] *Ibid*, pp. 530-533.
[16] Ehrenzueig, A.A: "Negligence without fault" 54 Cal LR 1422-78 (1966), cited *Ibid*, p. 531.

4.2 New Zealand

The New Zealand Accident Compensation Act, 1972, amended by the Accident Compensation Act, 1982, provides that an injured person or the dependant of a deceased person may claim compensation for injury or death resulting from "personal injury by accident",[17] including medical, surgical, dental or first aid misadventures on a no-fault basis.[18]

In this context, "personal injury by accident has been defined as "any form of damage to the human system which is unexpected and which was not designed by the person injured",[19] and "medical misadventure" to include "a mischance or accident, unexpected and undersigned, relating to medical treatment and arising out of a lawful act"[20]

The basic import of the Act as it relates to medical malpractice claim is that one need not prove medical negligence to be entitled to claim under the Act once the injury results from a medical misadventure under the Act. In other words, claims under the Act may embrace not only personal injury caused by medical negligence but also personal injury resulting from medical acts not amounting to negligence.

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[17] Accident Compensation Act, 1982, No 181, Section 2.
[18] Giesen, op-cit. p 532.
[19] (1981) NZACR 242 (243), cited *Ibid*.
[20] *Ibid*.

As Blaire J put it in ***Re Mrs MCR,*** [21] "if the legislature had intended to limit cover to injury resulting from medical negligence, it would not have use the new words 'medical misadventure' but rather utilized the well-understood words "medical negligence".

However, it is not all manner of medical mishap or misadventure that is contemplated as falling within the compensable injury under the Act. Those mishaps or injuries which are ordinarily foreseeable as normal consequences or risks attaching to medical treatment are excluded under the Act. This was emphasized by Speight, J in ***Accident Compensation Commission v. Auckland Hospital Board***.[22] According to His Lordship:

> [A]ll treatment, whether medical or surgical, has a chance of being unsuccessful. There is an expected failure rate in all these matters and such failure may be because no matter how correct the treatment, nature does not always respond in the desired way. --- Certainty cannot be underwritten--- Where there is an unsatisfactory outcome of treatment which can be classified as merely within the normal range of medical or surgical failure attendant upon even the most felicitous treatment, it could not be held to be a misadventure.[23]

The innovation of the Act can be seen in the fact that a claim may be in medical

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[21] (1978) 1 NZAR 567 at 571, cited *Ibid* at p. 533.
[22] (1981) NZACR 9 cited *Ibid*
[23] At p.13

negligence and also on injuries which ordinarily do not result from negligence but which are unexpected or not contemplated by medical competence and wizardry. Such unexpected injury which is not the fault of the doctor would not under the general law of medical negligence be compensable. But the Act compensates for same as an act of social welfare intervention in the life of the victim. Similarly, claims under the Act need not be in court as the Act is administered by the Accident Compensation Commission. In other words, claims may be easier, faster and cost effective since it is an administration rather than a judicial process.

4.3 Sweden

The Patient Insurance Scheme was introduced in Sweden in 1975[24] Prior to this time, the fault related compensation regime in the form of proving necessary causal connection between fault and injury was in force in Sweden.

The new scheme provides compensation on no-fault basis for victims of medical accidents, i.e., victims of injury which occurred as a result of medical treatment and was not an inevitable consequence of a previous sickness.[25] This scheme has wider coverage than the regime in New Zealand since the injury need not arise

[24]Patient Insurance for Injuries of Treatment: conditions of indemnity, 1982, Section 2.
[25] Act on Health and Medical Care, 1981, Giesen, *Op-Cit.* p. 542.

from medical misadventure but merely from "medical treatment" Thus, the patient need only prove that the injury results from medicare which may include ordinary medical treatment, healthcare related accidental and infection injuries, blood donations, ambulance transport, etc. However, injuries which are naturally and reasonably foreseeable as normal risk of medical treatment are excluded.[26]

4.4 Germany

The Federal Republic of Germany has taken a step in alleviating the problem of proof of connection between fault and injury in cases involving defective drugs. Through a statutory compensation scheme, victims of damage caused by defective drugs are entitled to compensation for death or personal injuries.[27] Under this regime, the injury complained of must exceed the normal tolerable limit resulting from defect in production or development of drugs. It excludes minor side effects of drugs. Drug producers are under the Act held strictly liable for:

(a) All their products;

(b) All products which are the result of a combination of their own product and products of others; and

[26] Giesen *OP. Cite.* p.542
[27] Drug Administration Act, 1976, as amended, 16 August, 1986

(c) Injury resulting from inadequate labeling or insufficient warning.

Liability also extends to the dependants of the deceased victim of a drug defect.[28] Although the German regime is restricted to compensation for injury resulting from drug defect only, the innovation lies in the introduction of strict liability of drug companies. This relieves the victim of proving that he was not at fault, thus shifting the onus of proof to the defendant drug company.

4.5 Viable Option for Nigeria

There is no doubt that the Nigerian state intends to set up a welfarist state.[29] As such the state should not be looking the other way while the victims of medial mishaps are suffering and labouring under economic strangulation, ignorance, delay and technicality of court process that deny them access to justice. This is moreso with the widespread medical malpractices prevailing in our hospitals.

Nigeria needs a clear legislation that would guarantee the right of every citizen to compensation for injury resulting from medical treatment on no-fault basis. Also a Commission should be established to administer such scheme, so that victims would be saved the delay, cost and the emotional over-hang that emit from court

[28] Giesen op-cit p. 544

[29] The Fundamental Objectives and Directive principles of state policy in chapter II of the 1999 constitution particularly sections 16 and 17 are evidence of this.

premises.

By this, the rate of medical malpractices claims would rise astronomically and the Nigeria health care delivery system would enjoy the resulting multiplier effect.

5 Conclusion

The importance of legislation as a source of law cannot be overemphasized. This is even more apposite in the area of medical and health care rights of patients. For one thing, Nigerian judicial decisions in this area are still scanty, so that heavy reliance is placed on common law. A comprehensive legislation in the form of Patients' Bill of Right will not only make the law concise, certain, accessible and a form of publicity of existing rights, but it will assist legal practitioners and courts involved in prosecuting and deciding on medical malpractice claims. Also, the prevailing policy in developed jurisdictions of providing assistance in the form of compensation to victims of medical misadventure as a matter of state welfare intervention in the health and welfare of the citizens rather than leaving the patients to their fate in the tortuous fault or delict approach can only be achieved by legislature process. In Nigeria where social welfare legislation is still a matter of debate, legislation in the mould of patients' compensation scheme would be very timely and auspicious.