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Nimi Erema Esq of Akuro R. George and associates also contributed in no small measure to the success of the book.

We are also grateful to colleagues in the University of Port Harcourt Teaching Hospital for their encouragement.

O.J. Odia
A.R. George
PREFACE TO SECOND EDITION

This book, first published in 2008, was written to address the knowledge gap of medical practitioners as regards Law and Ethics of medical practice. Most medical practitioners will agree that the medical curriculum does not adequately address ethical issues in medical and public health practice. It is also true as stated in the preface of the first edition, that patients are becoming more aware of their rights and therefore more litigation conscious.

This second edition of the Law and Ethics of medical practice in Nigeria has been reviewed and updated. Four new chapters; Introduction to biomedical ethics, principles of public health ethics, law and ethics of public health and ethical issues in health management of the elderly have been included. Chapter 4 and 5 of the first edition have been merged and updated.

Overall the reader will find that this edition in a vast improvement on the first one. This book will remain invaluable to medical and other health practitioners, as well as law students.

PROF O. J. ODIA.
PREFACE TO FIRST EDITION

It is becoming increasingly imperative for medical practitioners to pay attention to the laws and ethics of the medical profession. In a fast changing world, driven by technology and acquisition of knowledge, there is enhanced ability for patients to contribute to their welfare and medical management. This can provide a veritable platform for conflict and the perception of negligence and abandonment.

In writing this book we have made references to the various acts of the national assembly, other laws of the Nigerian Federation and international laws and conventions. References have also been made to the code of medical ethics as outlined by the Medical and Dental council of Nigeria and some reports of actual cases that have been brought before the medical and dental council disciplinary tribunals.

References have also been made to specific judgments of the various courts in Nigeria and beyond. The topics covered in this book include administration of law in Nigeria, research ethics, law of contract, professional liabilities, medical record keeping, laws of tort and medical jurisprudence. A special section deals with the responsibilities, industrial and professional rights and privileges of medical practitioners.

This book is timely and should fill the knowledge gap of medical and indeed legal practitioners in the area of law and ethics of medical practice. It is therefore highly recommended to all medical practitioners and health care providers. It also comes highly recommended to legal practitioners who may find it very useful in medico-legal practice.

Professor O. J. Odia
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CONTRIBUTORS

**Professor A. R. Nte** MBBS, FWACP  
Department of Pediatrics and Child Health  
University of Port Harcourt  
Port Harcourt

**Professor S. O. Nwosu** MBBS, FWACP, FICS  
Forensic Pathologist  
University of Port Harcourt  
Port Harcourt

**Mrs. D. Abbey** BA, MBA, LLB (Hons), B.L.  
Attorney at Law  
Former Secretary Ethics Committee  
University of Port Harcourt Teaching Hospital  
Port Harcourt

**DR O. Maduka.** MBBS, FMCPH  
Department of Preventive and Social Medicine  
University of Port Harcourt  
Port Harcourt.

**Dr H I Bell-Gam** MBBS, FWACP,  
Department of Medicine  
University of Port Harcourt  
Port Harcourt
1. INTRODUCTION TO LAW AND ETHICS IN MEDICAL PRACTICE

O.J. ODIA

The world is changing fast, so is medical practice. The practice of medicine is evolving rapidly in a world now driven by technology. The world has become a global public arena or village square. Therefore, changes in medical practice and complex ethical issues are emerging almost on a daily basis.

It has become imperative therefore, for medical practitioners, to pay particular attention to the laws and ethics governing their profession. This is more so because the relationship between doctors and other health care providers and their patients is no longer vertical. Patients now have access to the internet and other publications and may in fact research into their disease conditions and want to contribute to their treatment and medical welfare. This could easily generate conflict leading to complaints of neglect and abandonment and breach of ethics.

In today’s world, complex ethical issues have arisen. For example, ethics of organ transplantation; euthanasia or assisted death, surrogate motherhood, and stem cell research and applications contribute in no small measure to the ethical conundrums of the 21st century.

The medical practitioner must be vast not only in his medical field or specialty, but also must be alert to his duties and responsibilities in practice. He or she must be conversant with the laws and the ethics of the profession in order to avoid liability suits. Also the practitioner must be aware of the need for defensive practice and the need to anticipate legal issues before they occur. The practitioner should also be prepared to defend himself or herself in a court of law or before a professional disciplinary tribunal.

In view of liability suits and their increasing burden, practitioners should realize the importance of liability insurance cover. A
successful medical practitioner must have a working knowledge of not only the laws and ethics, but also of morality and protocol in medical profession.

He or she must understand that the pillar of successful practice rests on courtesy, compassion and common sense.

The following are qualities that a medical practitioner must thrive to possess.

- Courtesy and good listening skills.
- Good communication skills.
- Empathy for the patients and their relations.
- Relaxed, polite and friendly attitude.
- Ability to keep medical information confidential, no matter the circumstances.
- Must be willing to learn.
- Should relate well with colleagues and other members of the health team.

LAW AND ETHICS

Law
A law is defined as a prescribed rule of conduct or action enacted by government for proper function of the society. Laws are enforced by law enforcement agencies like the police and other bodies established for the purpose. Penalties for breach of laws are decided by courts of competent jurisdiction or specialized tribunals constituted for that purpose.

Those who breach the law are liable to be fined, or imprisoned. Apart from the general civil and criminal laws in a state or country, there are specific laws that govern the practice of medicine. Such laws are enacted by Federal, State or Local Governments. The laws regulate the establishments of clinics, hospital, pharmacies and medical diagnostic laboratories.
Ethics
Ethics consist of standards of behavior and the principle of right and wrong developed by professional regulatory bodies and associations. Ethical standards are usually held far beyond what is legal in a particular state or country.

The code of ethics of the medical profession transcends state, race, ethnicity or religious considerations and is usually held sacrosanct. The medical code of ethics originated from the tenets of the Hippocratic Oath, a modified form of which is administered to medical or dental practitioners on induction into their profession.

In Nigeria, the Medical and Dental Council of Nigeria (MDCN) regulates the practice of medicine by Doctors and Dentists and has published a code of ethics for practitioners. This code is revised periodically to meet with new ethical challenges.

A breach of ethics may lead to disciplinary tribunal which has the powers of a federal high court. The cases brought before the tribunal are usually investigated by an investigative panel consisting of medical and dental practitioners and a legal adviser.

THE MEDICAL AND DENTAL COUNCIL OF NIGERIA (MDCN)
The Medical and Dental Council of Nigeria regulates the practice of medical and dental professions in Nigeria.

The law setting up the Medical and Dental council is the Practitioners Act Cap 221 laws of the federation of Nigeria 1990. The law confers on the MDCN the following responsibilities:

- To determine the standards of knowledge and skill to be attained by persons seeking to become members of the medical and dental professions and to review those standards periodically.

- To secure according to the provisions of the law the establishment and maintenance of registers of persons entitled to
practice as members of the medical or dental profession and the publication from time to time, the list of registered persons.

- To prepare and review from time to time a statement as to the code of conduct it considers necessary for the practice of the profession in Nigeria.

- To perform other functions conferred on it under the law. In view of the responsibility to set ethical standards conferred on the MDCN by law, the Council is empowered to promulgate rules of professional conduct. It also has the power to set up a disciplinary tribunal and an investigatory panel to enforce the ethics or rules of conduct.

Penalties can be imposed on erring practitioners found guilty of breach of the ethics of the profession as follows:
- Admonishing the practitioner
- Suspending the practitioner from practice for a period not exceeding six months.
- Striking the practitioners name off the register of medical or dental practitioners.

The Medical and Dental Council of Nigeria has its main office in Abuja, the capital city of Nigeria. It also has zonal offices in Enugu, Lagos and Kaduna. The Council also has monitoring committee offices in each state of the federation. The monitoring offices are based in the offices of the Director of Medical Services in each state.

**REGISTRATION OF MEDICAL PRACTITIONERS**

In order to be eligible for registration as a medical or dental practitioner by MDCN, candidates must have had a university degree in medicine or dentistry from a medical school recognized by MDCN. The candidate must also have taken the physicians’ oath administered by the registrar of the MDCN or the head of an MDCN recognized medical school of graduation.
There are four types of registration as follows:

**Provisional Registration:**
This is for fresh graduates of medical schools who are yet to undergo the 12 month period of internship.

**Full Registration:**
A medical or dental graduate, who has successfully completed the mandatory period of internship and has been duly certified by his supervising consultants, is eligible to apply for full registration.

**Additional or Specialty Registration:**
Medical or dental practitioners who have had full registration and have had training in an area of specialty duly certified by a body recognized by the council are eligible for registration in the specialty of training and will be placed in a specialty register.

**Temporary or limited Registration:**
Non-Nigerians who wish to practice in Nigeria and possess the recognized requisite degrees are eligible to apply for placement in the temporary register of medical or dental practitioners in Nigeria.

These registrations are subject to periodic review by the Council.
THE PHYSICIANS’ OATH
I solemnly pledge myself to consecrate my life to the service of humanity;
I will give to my teachers the respect and gratitude which is their due;
I will practice my profession with conscience and dignity;
The health of my patient will be my first consideration
I will respect the secrets, which are confided in me, even after the patient has died.
I will maintain by all means in my power, the honor and noble traditions of the medical professions;
My colleagues will be my sisters and brothers;
I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.
I will maintain the utmost respect for human life;
I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
I make these promises solemnly, freely and upon my honor.

AFFIRMATION

I, ............................................................................................................................
Hereby affirm the oath I have just taken; so help me God.
INTERNATIONAL CODE OF MEDICAL ETHICS
DUTIES OF DOCTORS IN GENERAL

A DOCTOR MUST always maintain the highest standards of professional conduct.

A DOCTOR MUST practice his profession uninfluenced by motives of profit.

The following practices are deemed unethical:
- Any self-advertisement except such as is expressly authorized by the national code of medical ethics.
- Collaborate in any forms of medical service in which the doctor does not have professional independence.
- Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

ANY ACT OR ADVICE which could weaken physical or mental resistance of human beings may be used only in his interest.

A DOCTOR IS ADVICED to use great caution in divulging discoveries or new techniques or treatment.

A DOCTOR SHOULD certify or testify only to that which he or she has personally verified.

DUTIES OF DOCTORS TO THE SICK

A DOCTOR MUST ALWAYS bear in mind the obligation of preserving human life.

A DOCTOR OWES to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity, he should summon another doctor who has the necessary ability.
A DOCTOR SHALL preserve absolute secrecy on all he knows about his patient even after the patient has died because of the confidence entrusted to him.

A DOCTOR MUST give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

DUTIES OF DOCTORS TO EACH OTHER
A DOCTOR OUGHT to behave to his colleagues as he would have them behave to him.

A DOCTOR MUST NOT entice patients from his colleagues.

A DOCTOR MUST OBSERVE the principles of “The Declaration of Geneva” approved by the World Medical Association.
HIPPOCRATIC OATH
I swear by Apollo, the physician and Aesculapius and Health, and all the gods and goddess, that according to my ability and judgment, I will keep this oath and stipulation, to reckon him taught me this art equally dear to me as my parents, to share my substance with him and relieve his necessities if required; to regard his offspring as on the same footing with my own brothers, and to teach them this art if they should wish to learn it, without fee or stipulation, and that by precept, lecture and every other mode of instruction, I will impart a knowledge of the art to my own sons and to those of my teachers, and to disciples bound by a stipulation and oath, according to the law of medicine, but to none other.

I will follow that method of treatment which according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is delirious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel. Furthermore, I will not give to a woman an instrument to produce abortion.

With purity and holiness I will pass my life and practice my art. I will not cut a person who is suffering with a stone, but will leave this to be done by practitioners of the work. Into whatever houses I enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or males, bond or free.

Whatever, in connection with my professional practice, or not in connection with it, I may see or hear in the lives of men which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret.

While I continue to keep this oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men at all times, but should I trespass and violate this oath, may the reverse be my lot.
GENERAL PRINCIPLES OF THE ETHICS OF MEDICAL AND DENTAL PRACTICE IN NIGERIA.

The principal objectives of the medical or dental practitioner shall be the promotion of the health of the patient but in doing so the practitioner shall also be concerned for the common good while at the same time according full respect to the human dignity of the individual.

Practitioners have a responsibility in promoting not only individual health but also the general health of the community and in pressing for an equitable allocation of health resources.

Practitioners must strive at all times not only to uphold the honor and maintain the dignity of the profession but also to improve it.

Practitioners shall deal honestly with colleagues and patients at all times.

Practitioners must always strive to observe the laws of the land but may participate individually or collectively in accordance with citizenship rights to bring pressure to bear on government or authorities to change or modify laws or actions considered inequitable or inimical to the interest of the profession or the society.

Medical and Dental practitioners shall try at all times to safeguard the public and the medical and dental professions against incompetent or unethical practitioners and should expose without hesitation professional malpractice and infamous conduct to the Medical and Dental Council of Nigeria.

All communications between the patient and the practitioner made in the course of treatment shall be treated in strict confidence by the practitioner and shall not be divulged unless compelled by law or overriding common good or on consent of the patient.

Practitioners shall be at liberty to choose whom they will serve in rendering their professional service but they shall endeavor to render
service without discrimination in an emergency to the best of their ability according to the prevailing circumstances.

Practitioners shall have absolute discretion and authority free from unnecessary non-medical interference in determining when to give their services and the nature of care to be given to a patient under their care and must accept responsibility for their actions.

Practitioners must always strive to improve their medical knowledge and skill, and must always practice according to accepted scientific principles in rendering care to patients and shall not hesitate to seek the consultation of more experienced or appropriate specialist colleagues whenever they are in doubt or lacking competence.

Practitioners may not associate professionally with non-medically qualified people but shall ensure that in collaboration with any member of the allied profession or Para professions, such members are recognized members of their discipline and are competent to perform the task to be required of them. In all such relationship the practitioner shall retain the absolute authority and responsibility for the patient and should not delegate any exclusive professional medical responsibility to any non-medical or non-dental person.

Practitioners must not certify to what they have not personally verified; they must desist from compulsory treatment of patient in the absence of illness and must not collaborate with other agencies to label somebody ill in the absence of any illness, but must always obtain before embarking on special treatment procedures with determinable risks.

In performing biomedical research involving human subjects, practitioners must conform to generally acceptable scientific and moral principles and must obtain informed consent from their subjects and take responsibility to ensure the protection of their integrity and confidence.
Practitioners shall be entitled to charge fees for their professional services but such income should be limited to professional services actually rendered, supervised or for missed appointments and should be commensurate with the service rendered and the patient’s ability to pay; fee splitting and payment for referrals are forbidden.

Practitioners should safeguard against publicity in the media that imply that a practitioner has special skills or that expose the identity of a patient but should be circumspect in the announcement of any new special procedures of discoveries and must always strive for anonymity for himself and the patient in any public forum.

Practitioners shall be entitled to describe their professional and academic titles after their names but in doing so, care must be taken to avoid unethical advertising in an attempt to solicit patients.

**MEDICAL AND DENTAL PRACTITIONERS DISCIPLINARY TRIBUNAL**

The Medical and Dental Practitioners Disciplinary Tribunal has the status of a high court of the Federal Republic of Nigeria and practitioners who appear before it whether as complainants, defendants or witnesses, whether or not they are also represented by a lawyer, must conduct themselves as they would before a high court. This code of behavior is equally applicable to counsel who appear at the Tribunal.

Practitioners who make public comments on cases pending before the Medical and Dental Practitioners Investigating Panel or Disciplinary Tribunal, or cases where the time for appeal has not expired, shall be guilty of contempt of the panel or the Tribunal, as the case may be, and shall be liable to appropriate disciplinary action. Any doctor who may wish to contest the judgment can only go to the Appeal Court.
MEDICAL AND DENTAL PRACTITIONERS INVESTIGATING PANEL

The Medical and Dental Practitioners Investigating Panel is a court of first hearing in matters of alleged ethical misconduct that are properly brought before the Medical and Dental Council of Nigeria.

A doctor should be punctual whenever summoned to appear before the panel in the course of the investigation of any case which involves him, whether as the defendant doctor or as a witness. He should give prompt notice to the appropriate official of the Council with regard to any circumstances that would cause his/her tardiness or absence.

A registered practitioner who has been notified by the panel of the necessity for his/her appearance before the panel, for whatever reason, shall attend relevant hearings, as and when invited, in case the practitioner would travel out of Nigeria whilst the matter is yet to be disposed of, he is required to duly notify the appropriate official of the Council and obtain the necessary clearance before traveling out.

A doctor or dental surgeon, as the case may be, who has been duly notified that he has to appear before the panel in an ongoing investigation but who fails to appear, whenever due without an acceptable excuse shall be liable to disciplinary action. Practitioner’s duty to appear before the panel is continuous from the time of the first notification until the matter under investigation is finally disposed of.

Any attempt to curry favors with panel members through flattery or pretended solicitude for personal comfort would constitute an unprofessional conduct.

Doctors should rise when addressing, or being addressed by, the panel unless the Chairman of the panel directs otherwise.
The Council shall on the recommendation of either of its disciplinary organs, communicate to a foreign Medical Council when appropriate, relevant information on a registered practitioner, when it is obvious that the Medical and Dental Council of Nigeria is being ignored. The purpose of such communication will be to compel the registered practitioner to assist the disciplinary organs in treating the matter before them, in which he is involved.
EXCERPTS FROM THE MDCN CODE OF MEDICAL ETHICS IN NIGERIA

Humanitarian doctors

All medical and dental practitioners wishing to render health services to the public are very welcome. However short or long the period of such service may be, it is mandatory in the case of expatriate doctors that a limited registration and current practicing license as the case may be should be obtained before undertaking such exercises. It should be the responsibility of the organization or individual responsible for bringing in such doctors to ensure that they are duly registered and licensed prior to arrival in Nigeria-

MDCN code of medical ethics in Nigeria 7c 2004 pg. 14
**Fitness to practice**

Practitioners like any members of the society are prone to various ailments and detestable habits. To some extent these ailments and habits do not only impair the productivity, judgment and alertness of practitioners but can render them unreliable.

The council views the following conditions which could render a practitioner unsafe and constitute obstacles of fitness to practice medicine or dentistry:

- A practitioner suffering from physical or mental condition which can imperil his patients, embarrass his professional colleagues and indeed jeopardize his own career and professional position.
- A practitioner suffering from senile dementia.
- A practitioner who has become addicted to drugs and might or indeed does commit offences against the Dangerous Drugs Act and Regulation.
- A practitioner addicted to alcohol that might or is not in the right frame of mind to treat patients.

**Procedure to determine fitness of practice**

It is envisaged that problems with methodology of determining fitness to practice will be encountered. Practitioners would raise objections as to the validity and credence. The following procedure will go a long way to eliminate any misgivings:

I. The council shall set up an ad-hoc committee on practitioner’s health consisting of the following members, each of whom shall not be less than fifteen (15) years post registration.
   - A physician
   - A psychiatrist
   - A community Health/Occupational physician
   - A dentist
   - One (1) other member.
II. The Committee on Practitioners Health (CPH) shall receive complaints, consider them and if satisfied that a question arises whether the doctor’s fitness to practice has become seriously impaired, shall give the practitioner three weeks to submit to examination by at least two examiners.

III. The Committee on Practitioners Health (CPH) shall consider reports of the examiners and make recommendation to council as appropriate. The registrar of council shall advise the practitioner accordingly, as the council may direct. Where treatment is applicable, the practitioner shall be advised to submit to treatment.

IV. When the practitioner refuses to submit to examination or to treatment, the Committee on Practitioners Health (CPH) shall lay a complaint before the medical and dental practitioners investigating panel, which shall attend to the matter as appropriate.

MDCN code of medical ethics in Nigeria 79 2004 pg 71
Biomedical ethics is a branch of bioethics which was mainly developed by philosophers, theologians and civil liberties organizations as well as physicians. Traditional medical ethics however, was developed by medical practitioners down the ages from the time of Hippocrates in the 4th Century BC. Biomedical ethics seeks to formulate basic principles that can be used to resolve ethical dilemmas that may or may not have precedence.

After the Second World War, abuses committed by researchers in Nazi Germany were investigated leading to the Nuremberg trials of 1946. Twenty three German physicians that took part in Nazi programs to euthanize persons they thought were unworthy to live were tried. One hundred and forty days, 85 witnesses and 1500 documents later, 16 of the doctors were found guilty. As a result of this, the research code, known thereafter as the Nuremberg Code was established in 1947.

Other biomedical ethics research codes have been developed by other medical research bodies. Rapid development of medical technology has made the traditional medical ethics guidelines sometimes incapable of resolving ethical conundrums.

For example, the development of in-vitro fertilization and assisted conception technologies and organ transplants are relatively new in medical practice with peculiar ethical challenges. Also other social and political developments have led to the development of biomedical ethical principles. Increases in knowledge from social media, value pluralism, multiculturalism and public awareness of health issues have led to a shift from traditional ethical solutions to ethical principles referred to as principlism.

In 1979, Beauchamp and Childress developed the four principles of biomedical ethics. In retrospect, these four principles can be seen as a consensus between deontology and utilitarianism. Deon refers to
duty. Deontological ethics theories are derived from duty based ethics. Thus by this principle an action is right if it follows moral duties or actions. Utilitarianism as an ethical theory is based on the concept that an action is right if it does good to the majority of people. This is also referred to as consequentialist in the sense that the action provides an intrinsically valuable consequence.

The four principles as enunciated by Beauchamp and Childress have been found very useful in resolving ethical issues in research and medical practice. The four principles consist of Autonomy or Self Rule, Beneficence (the duty to do good), non-maleficence (not doing harm) and justice.

Another way of resolving ethical issues is paternalism, sometimes referred to as parentism. Paternalism can be defined as an action of an individual usually a parent, relative, legal guardian or an organization or a country which limits or interferes with the individuals will or autonomy for the person’s (patient’s) own good. This is done mainly to prevent the individual from self-harm. Paternalism is easily justified in children or in persons that are judged not capable of making their own decisions appropriately. Paternalism becomes controversial when it is applied to non-minors and individuals or groups that are capable of making their own decisions.

Paternalism is sometimes described as soft or mild when it is non-coercive. Hard paternalism on the other hand is coercive. Paternalism can be used to resolve some ethical issues based on the premise that the patron or organization taking the decision on behalf of the adult patient is more rational and knowledgeable than the patient. For example the relatives of a patient could be allowed to override the autonomy of the patient in availing permission for amputation of a gangrenous foot to save the life of the patient even when the patient does not give his or her consent. Relatives may also override the decision of patients to refuse chemotherapy when doctors recommend its use in treating a patient with cancer.
In public health services, patients with infectious diseases like Ebola can be quarantined or isolated against their will. Also individuals are forced to wear seat belts. Euthanasia is illegal in many countries including Nigeria. Therefore the Nigerian State plays the paternal role is refusing euthanasia in whatever form to a dying patient despite the express wish of the patient to be allowed to die with dignity. Doctors are advised to seek proper legal counsel when they want to use paternalism to resolve ethical issues.

**RELATIONSHIP BETWEEN LAW, CULTURE, RELIGION AND BIOMEDICAL ETHICS**

Despite the above stated ethical principles, various communities resolve ethical dilemmas against the background of their various laws, cultural and religious beliefs or standards. For example the law on euthanasia is deeply rooted in the culture and religious beliefs in the sanctity of human life. Similarly, assisted conception may or may not be acceptable to the individual based on his or her religious belief and cultural background. Abortion in Nigeria still remains illegal as a result of strong cultural and religious opposition to it.
3. PRINCIPLES OF PUBLIC HEALTH ETHICS

O. MADUKA

The 25th article of the Universal Declaration of Human Rights written right after the end of World War II, largely in response to the atrocities of that war, states that “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family.”

After this declaration, the World Health Organization went on to define health as ‘a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity’.

The pursuit of this idealist goal of complete well-being is largely through the two major arms of health care delivery; Medicine and Public Health.

Public Health as defined by Winslow ‘is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency, through organized community efforts, for the sanitation of the environment, the control of community infections, the education of the individual in the principles of personal hygiene, the organization of medical and nursing services for the early detection and preventive treatment of disease, and the development of the social machinery which will ensure to every individual in the community a standard of living adequate for the maintenance of health’.

Acheson puts it more succinctly as ‘the science and art of preventing diseases, promoting health and prolonging life through organized effort of society’.

The role of Public Health as defined by the Institute of Medicine is to ‘contribute to the health of the public through assessment of health and health needs, policy formulation, and assurance of the availability of services’. The dimensions of Public Health include preventive medicine, social medicine, community health and community medicine.
PUBLIC HEALTH ACTIONS
The Public Health Service division of the United States Health and Human Services Public Health classifies Public Health Action into ten (10) core activities
1. Preventing Epidemics
2. Protecting the environment, workplaces, food and water
3. Promoting healthy behavior
4. Monitoring the health status of the population
5. Mobilizing community actions
6. Responding to disasters
7. Assuring the quality, accessibility and accountability of medical care
8. Reaching out to link high-risk and hard-to-reach people to needed services
9. Researching to develop new insights and innovative solutions
10. Leading the development of sound health policy and planning

ESSENTIAL PUBLIC HEALTH SERVICES
In line with these core activities, the 10 essential Public Health services include:
1. Monitor the health status to identify community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure a competent public health and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

In order to address all these core activities and essential public health services, Public Health efforts must have the following characteristic: it must be multidisciplinary, multisectoral, evidence-based and equity-oriented. These characteristics underscore the ethical considerations for the practice of public health.

PUBLIC HEALTH ETHICS
Public health ethics involves a systematic process to clarify, prioritize and justify possible courses of public health action based on ethical principles, values and beliefs of stakeholders.

It can be subdivided into a field of study and a field of practice. As a field of study, public health ethics seeks to understand and clarify principles and values which guide public health actions. Principles and values provide a framework for decision making and a means of justifying decisions. Because public health actions are often undertaken by governments and are directed at the population level, the principles and values which guide public health can differ from those which guide actions in biology and clinical medicine (bioethics and medical ethics) which are more patient or individual-centered.

As a field of practice, public health ethics is the application of relevant principles and values to public health decision making. In applying an ethics framework, public health ethics inquiry carries out three core functions, namely:

a. Identifying and clarifying the ethical dilemma posed,

b. Analyzing it in terms of alternative courses of action and their consequences, and

c. Resolving the dilemma by deciding which course of action best incorporates and balances the guiding principles and values.
MEDICAL ETHICS AND PUBLIC HEALTH ETHICS

Figure 1: Overlaps and Distinctions between Medicine and Public Health

The diagram above illustrates the similarities and differences between ethical issues in medicine and public health. Public health ethics partially overlaps the medical ethics circle. The place where they overlap shows that they both relate to health and so have some concerns in common. However, each also has some unique concerns, reaching where the other circle does not. It has been said that the difference between Public Health and Medicine can be illustrated in the actions taken when a bridge collapses downstream and people are drowning. While Medicine would busy itself in attempting to rescue those who have fallen in and are drowning downstream, Public Health is more likely to be thinking ‘upstream’ to identify people who may be coming into the same fate if they are not warned/prevented. Public Health would consider how to mobilize community action to understanding the causes of the bridge collapse and the strategies to stop further collapse and rebuild the bridge. Both approaches are relevant and vital to achieving ‘health for all’.

Until recently, public health ethics was regarded by many as if it were a circle that resided entirely inside of the medical ethics circle. However, the formation and management of programs and policies that protect the health of a community are clearly different from the
diagnosis and treatment of disease, which are at the core of medicine.

The ethical theories underpinning the practice of medicine as described in the preceding chapter, include autonomy, beneficence, non-maleficence and justice. These principles though very relevant to health provider and patient relationship do not have wide applicability with institutions- community interactions over public health issues. The ethical theories that form the basis of Public ethic ethics include Utilitarianism, Rights and Duty.

Table 1: Contrasting Medical Ethics and Public Health Ethics

<table>
<thead>
<tr>
<th>Situations</th>
<th>Medical Ethics</th>
<th>Public Health Ethics</th>
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<tr>
<td></td>
<td>Patient–provider interactions</td>
<td>Institutions and populations</td>
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<tr>
<td>Key theories</td>
<td>• Autonomy</td>
<td>• Utilitarianism</td>
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<td></td>
<td>• Beneficence</td>
<td>• Human rights</td>
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<td></td>
<td>• Non-maleficence</td>
<td>• Duty</td>
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<td></td>
<td>• Justice</td>
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Theories of Public Health Ethics

1. **Utilitarianism:** This refers to the notion that objective and scientific decisions need to be taken that maximize the happiness of the majority of a population or group. Its strength lies in that fact that to achieve this many considerations and options are analyzed before decisions are taken. The weakness however is that decision taken based on the majority can have negative or even dangerous consequences for the minority. This phenomenon is referred to as the ‘tyranny of the majority’

2. **Human Rights:** Human rights have become an important part of public health ethics. This theory evolved as a defense against the abuses of the government. The famous United Nations’ Universal Declaration of Human Rights after the Second World War was in reaction to the atrocities committed in the Nazi concentration camps. This theory serves to correct the tyranny of
the majority. However it has the tendency to be difficult to determine and agree upon. It also serves as a tool for groups to antagonize the government without just cause, and it gives a false sense of entitlement so that people can claim all manner of rights.

3. **Duty:** This is the flip side of rights. Where there is a right there is also a duty to uphold and protect those rights. This theory does not give room for entitlement, and it has the potential to elicit great sacrifices from those tasked with the performance of duty. As a limitation however, it is sometimes difficult to decide who determines what duties a person or establishment has. In addition, it is possible for duties to be performed mechanically or for selfish gain without really caring about the rights that the performance of the duty is expected to uphold.

![Diagram](Figure 2: From the Theory of Public Health Ethics to the Practice of Public Health Ethics)

**RATIONALE FOR THE ETHICAL PRACTICE OF PUBLIC HEALTH**

The application of the theories of public health ethics to common public health situations have led to key ethical principles and professional code of the practice of Public Health ethics. Public health is concerned more with populations than with individuals, and more with prevention than with cure. Thus, it includes those who are not presently ill, and for whom the risks and benefits of medical care are not immediately relevant. Therefore ethical issues that apply to the practice of clinical medicine cannot be applied hook line and sinker to the practice of public health. At the very center of public health ethics is the need to exercise the powers to ensure the health and well-being of communities and groups while curtailing any potential abuses of this power.
Over the decades, the challenges to public health have increased astronomically. Technological advancements while broadening the horizons for health possibilities have also introduced new and complex ethical dilemmas. The fast pace of research into new frontiers of health interventions throw up its own complex set of ethical issues relating to confidentiality, autonomy, beneficence and non-maleficence. Finally, the advent of emerging and re-emerging disease epidemics and pandemics such as H1N1 influenza, bird flu, swine flu and the recent epidemic of ebola virus disease have tasked national and global public health organizations with ethical conundrums.

**PRINCIPLES OF THE ETHICAL PRACTICE OF PUBLIC HEALTH**

Values refer to concepts we place significance or importance in. A belief is that which we hold to be true even though we might not have evidence for. The following eleven (11) values and beliefs are key assumptions inherent to a public health perspective. They underlie the twelve (12) Principles of the Ethical Practice of Public Health. These eleven values and beliefs relate to health, community and bases for action. Health in itself is an important value and belief. Under Community there are six values and beliefs that are prominent in a public health perspective. They relate to interdependence, trust, collaboration, dependence on the environment, participation, and the fundamental requirements for a healthy community. Bases for action include four values and beliefs namely; the power of knowledge, Scientific method, Responsibility for what we know and Action based on principle. These eleven values and beliefs form the basis for understanding and applying the Code of Public Health Ethics.

**Health**

1. **Health:** Humans have a right to the resources necessary for health. The Public Health Code of Ethics affirms Article 25 of the Universal Declaration of Human Rights, which states in part “Everyone has the right to a standard of living adequate for the health and well-being of himself and his family…”

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Community

2. **Interdependence:** Humans are inherently social and interdependent. Humans look to each other for companionship in friendships, families, and community; and rely upon one another for safety and survival. Positive relationships among individuals and positive collaborations among institutions are signs of a healthy community. The rightful concern for the physical individuality of humans and one’s right to make decisions for oneself must be balanced against the fact that each person’s actions affect other people.

3. **Trust:** The effectiveness of institutions depends heavily on the public’s trust. Factors that contribute to trust in an institution include the following actions on the part of the institution: communication; truth telling; transparency (i.e., not concealing information); accountability; reliability; and reciprocity. One critical form of reciprocity and communication is listening to as well as speaking with the community.

4. **Collaboration:** This is a key element to public health. The public health infrastructure of a society is composed of a wide variety of agencies and professional disciplines. To be effective, they must work together well. Moreover, new collaborations will be needed to rise to new public health challenges.

5. **Dependence on the environment:** People and their physical environment are interdependent. People depend upon the resources of their natural and constructed environments for life itself. A damaged or unbalanced natural environment, and a constructed environment of poor design or in poor condition, will have an adverse effect on the health of people. Conversely, people can have a profound effect on their natural environment through consumption of resources and generation of waste.

6. **Participation:** Each person in a community should have an opportunity to contribute to public discourse. Contributions to discourse may occur through a direct or a representative system of government. In the process of developing and evaluating
policy, it is important to discern whether all who would like to contribute to the discussion have an opportunity to do so, even though expressing a concern does not mean that it will necessarily be addressed in the final policy.

7. **Fundamental requirements for a healthy community:** Identifying and promoting the fundamental requirements for health in a community are of primary concern to public health. The way in which a society is structured is reflected in the health of a community. The primary concern of public health is with these underlying structural aspects. While some important public health programs are curative in nature, the field as a whole must never lose sight of underlying causes and prevention. Because fundamental social structures affect many aspects of health, addressing the fundamental causes rather than more proximal causes is more truly preventive.

**Bases for Action**

8. **Knowledge:** Knowledge is important and powerful. We are to seek to improve our understanding of health and the means of protecting it through research and the accumulation of knowledge. Once obtained, there is a moral obligation in some instances to share what is known. For example, active and informed participation in policy-making processes requires access to relevant information. In other instances, such as information provided in confidence, there is an obligation to protect information.

9. **Scientific method:** Science is the basis for much of our public health knowledge. The scientific method provides a relatively objective means of identifying the factors necessary for health in a population, and for evaluating policies and programs to protect and promote health. The full range of scientific tools, including both quantitative and qualitative methods, and collaboration among the sciences is needed.

10. **Responsibility for what we know:** People are responsible to act on the basis of what they know. Knowledge is not morally
neutral and often demands action. Moreover, information is not to be gathered for idle interest. Public health should seek to translate available information into timely action. Often, the action required is research to fill in the gaps of what we don’t know.

11. **Action based on principle:** Action is not based on information alone. In many instances, action is required in the absence of all the information one would like. In other instances, policies are demanded by the fundamental value and dignity of each human being, even if implementing them is not calculated to be optimally efficient or cost-beneficial. In both of these situations, values inform the application of information or the action in the absence of information.

**CODE FOR THE ETHICAL PRACTICE OF PUBLIC HEALTH**

(as prescribed by the Public health Leadership Society in 2002)

1. **Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.**
   This principle gives priority to prevention of disease and promotion of health. The principle also acknowledges that public health will also concern itself with some immediate causes of disease and some curative roles. For example, the treatment of curable infections is important to the prevention of transmission of infection to others.

2. **Public health should achieve community health in a way that respects the rights of individuals in the community.**
   This principle identifies the common need in public health to weigh the concerns of both the individual and the community. There is no ethical principle that can provide a solution to this perennial tension in public health. However, the interest of the community is the primary interest of public health. Still, there remains the need to pay attention to the rights of individuals when exercising the police powers of public health.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members. A process for input can be direct or representative. In either case, it involves processes that work to establish a consensus. While democratic processes can be cumbersome, once a policy is established, public health institutions have the mandate to respond quickly to urgent situations. Input from the community should not end once a policy or program is implemented. There remains a need for the community to evaluate whether the institution is implementing the program as planned and whether it is having the intended effect. The ability for the public to provide this input and sense that it is being heard is critical in the development and maintenance of public trust in the institution.

4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health care accessible to all. This principle speaks to two issues: ensuring that all in a community have a voice; and underscoring that public health has a particular interest in those members of a community that are underserved or marginalized. While a society cannot provide resources for health at a level enjoyed by the wealthy, it can ensure a decent minimum standard of resources. The Code does not prescribe action when it comes to ensuring the health of those who are marginalized because of illegal behaviors. It only underscores the principle of ensuring the resources necessary for health to all. Each institution must decide for itself what risks it will take to achieve that.

5. Public health should seek the information needed to implement effective policies and programs that protect and promote health. This principle is a mandate to seek information to inform actions. The importance of information to evaluate programs is also implied.

6. Public health institutions should provide communities with the information they have that is needed for decisions on
policies or programs and should obtain the community’s consent for their implementation.
This principle is linked to the third one about democratic processes. Such processes depend upon an informed community. The information obtained by public health institutions is to be considered public property and made available to the public. This statement is also the community-level corollary of the individual-level ethical principle of informed consent. Particularly when a program has not been duly developed with evaluation, the community should be informed of the potential risks and benefits, and implementation of the program should be premised on the consent of the community (though this principle does not specify how that consent should be obtained).

7. **Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.**
Public health is active rather than passive, and information is not to be gathered for idle interest. Yet the ability to act is conditioned by available resources and opportunities, and by competing needs. Moreover, the ability to respond to urgent situations depends on having established a mandate to do so through the democratic processes of ethical principle number three.

8. **Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.**
Public health programs should have built into them a flexibility that anticipates diversity in those needs and perspectives having a significant impact on the effectiveness of the program. Types of diversity, such as culture and gender, were intentionally not mentioned. Any list would be arbitrary and inadequate.

9. **Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.**
This principle stems from the assumptions of interdependence among people, and between people and their physical
environment. It is like the ethical principle from medicine, “do no harm,” but it is worded in a positive way.

10. **Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.**

   This statement begs the question of which information needs to be protected and what the criteria are for making the information public. The aims of this statement are modest: to state explicitly the responsibility inherent to the “possession” of information. It is the complement to Ethical Principles 6 and 7, about acting on and sharing information.

11. **Public health institutions should ensure the professional competence of their employees.**

    The criteria for professional competence would have to be specified by individual professions, such as epidemiology and health education.

12. **Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public’s trust and the institution’s effectiveness.**

    This statement underscores the collaborative nature of public health while also stating in a positive way the need to avoid any conflicts of interest that would undermine the trust of the public or the effectiveness of a program.
<table>
<thead>
<tr>
<th>S.NO</th>
<th>Essential Public Health Services</th>
<th>Ethical Principles</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Monitor the health status to identify community health problems</td>
<td>(5) collect information (7) act on information</td>
</tr>
<tr>
<td>2</td>
<td>Diagnose and investigate health problems and health hazards in the community</td>
<td>(5) collect information</td>
</tr>
<tr>
<td>3</td>
<td>Inform, educate, and empower people about health issues</td>
<td>(4) advocacy and empowerment (6) provide information</td>
</tr>
<tr>
<td>4</td>
<td>Mobilize community partnerships to identify and solve health problems</td>
<td>(12) collaboration</td>
</tr>
<tr>
<td>5</td>
<td>Develop policies and plans that support individual and community health efforts</td>
<td>(1) protect and promote health; address fundamental causes of health risk (3) processes for community input (5) collect information</td>
</tr>
<tr>
<td>6</td>
<td>Enforce laws and regulations that protect health and ensure safety</td>
<td>(2) achieve community health with respect for individual rights (3) feedback from the community (7) act upon information</td>
</tr>
<tr>
<td>7</td>
<td>Link people to needed personal health services and assure the provision of health care when otherwise unavailable</td>
<td>(4) advocate for and empower; basic resources available to all (8) incorporate diversity</td>
</tr>
<tr>
<td>8</td>
<td>Assure a competent public health and personal health care workforce</td>
<td>(11) professional competence</td>
</tr>
<tr>
<td>9</td>
<td>Evaluate effectiveness, accessibility, and quality of personal and population-based health services</td>
<td>(3) community feedback (5) collect information</td>
</tr>
<tr>
<td>10</td>
<td>Research for new insights and innovative solutions to health problems</td>
<td>(9) enhance physical and social environments (10) protect confidentiality</td>
</tr>
</tbody>
</table>
4. LAW AND ETHICS OF PUBLIC HEALTH IN NIGERIA

O. MADUKA

Although there is an appreciable overlap between Public Health ethics and Public Health Laws these two are not synonymous with each other. The definitions for law and ethics, as well as the similarities and differences between these two concepts have been described in Chapter one. Legal powers and ethics in Public Health are usually practiced by Public Health Institutions or agencies.

PUBLIC HEALTH AGENCIES/INSTITUTIONS

These are institutions that have direct or indirect influence on Public Health can be classified into private corporations and government agencies.

Private corporations: Private companies do not have a specific mandate to promote and protect the health of the public. The influences of corporations on public health are often seen as negative e.g. the tobacco and fast food industries but they also have many important positive influences on the health of the public e.g. the provision of employment and an income that enables people to obtain food, clothing, and shelter.

Government institutions and agencies: The mandate to promote and protect the health of the public lies directly within the purview of government health and development agencies and institutions. They exist at the Federal, State and Local Government levels. These agencies have various legal powers and use various tools to directly provide some services and to regulate those functions of individuals and companies that have an effect on the health of the public. Examples of these institutions and agencies in Nigeria include; the Federal Environmental Protection Agency, the National Environmental Standards and Regulations Enforcement Agency, the National Agency for Food and Drugs Administration and Control, the Standard Organization of Nigeria, the National Agency for Oil Spill Detection and Control, the Federal Ministry of Health, the
Federal Ministry of Environment, the various Federal Courts (Federal High Court, Court of Appeal and the Supreme Court), the State Ministries of Health and Environment, Local Government Health Authority

PUBLIC HEALTH LAWS AND POWERS
Traditionally four (4) categories of Public health laws and powers are granted government public health authorities. These include:
1. Disease surveillance
2. Treatment and immunization
3. Isolation and confinement
4. Regulation

PUBLIC HEALTH LAWS IN NIGERIA
Public health laws are made to regulate public health services and ensure environmental protection. A breach of these laws attracts sanction or punishment. Public Health laws in Nigeria cover refuse collection and disposal, notification of epidemic and quarantine services, air pollution, water pollution, noise pollution, building erection, sales of food, disposal of corpse and other carcasses, land pollution, industrial waste disposal, toxic waste disposal, drug testing and immunization or vaccination, environmental impact assessment, petroleum exploration and exploitation, the polluter pay principle, the precautionary principle and the principle of sustainable development.

The solid waste and refuse disposal law: This law regulates the collection, treatment and disposal of all solid and hazardous refuse and waste from households, industries and other sources. It also includes maintenance of the aesthetic beauty of dwelling places and the environment through provision of green areas, pest and vector control, safe water supply, maintenance of drainage, good refuse bins and gutters. This is provided for under section 15 of the Federal Environmental Protection Agency Decree No. 58 of 1988 and 59 of 1992 which amended the principal Decree now Act of the National Assembly, the National Guidelines and Standards for Environmental Pollution control in Nigeria, 1991 and the Pollution Abatement in
Industries and Facilities Generating Waste of 1991, and the various State Environmental Protection Agency laws especially the State Environmental Sanitation laws.

**Disease notification and quarantine service law:** This law prescribes that people at all levels including the international community should notify government health agencies of the occurrence of certain international notifiable diseases. The World Health Organizations’ International Health Regulations of 1969 required the reporting of some diseases to the organization in order to help with its global surveillance and advisory role. The 1969 regulations were limited to reporting on three main diseases: cholera, yellow fever and plague. The revised International Health Regulations of 2005 has broadened the scope to include emerging diseases such as Avian Influenza, SARS, Ebola virus, mad cow disease among others. Furthermore, it is no longer limited to the notification of specific diseases but now covers any condition that can be classified as a public health emergency of international concern.

It also defines a limited set of criteria to assist in deciding whether an event is notifiable to the WHO. Under this law, a person’s freedom of movement or liberty may be derogated if it has been determined that they may be infected and may possibly transmit the infection. It also requires governments to take immediate measures to combat the spread of such diseases and where unable seek international assistance.

**Air pollution law:** This law prohibits the emission of chemical substances that are injurious to human health into the atmosphere. Specifically it limits the emission of carbon dioxide and greenhouse gases. These substances do not only have harmful effect on human health but also deplete the ozone layer and has led to acid rains, global warming, rise in level of sea water, deforestation and desertification. Air pollution is regulated by the Factories Act. Cap. 126 LFN, 1990 and the Federal Environmental Protection Agency Act Cap 131 LFN 1990.
**Water pollution law:** This law prohibits the dumping of any hazardous waste capable of causing harm to human and marine life into water bodies. Water pollution is one of the most common sources of pollution because industries, especially in petroleum exploring areas like the Nigerian Niger Delta area often discharge their waste into water or inadvertently cause water pollution. Water pollutants can be very harmful to humans when consumed at the secondary stage from sea foods. The first major incidence of water pollution resulting from mercury poisoning was the Minimata Bay pollution disaster in Japan in the year 1959. This resulted in death of domestic animals like cats, fishes and humans. Water pollution is regulated by several laws including the Water Workers Act, 1915, the Mineral Act, 1917, Public Health Act, 1917, the Petroleum Act, 1969, Sea Fisheries Act, Cap 401 LFN 1990, the River Basin Development Authority Act, Cap 396 LFN 1990, Oil in Navigational Water Act, Cap 339 LFN, 1990, Exclusive Economic Zone Act, Cap 16 LFN 1990, the Law of the Sea Convention, 1982 and the Federal Environmental Protection Agency Act among others.

**Law relating to drug and vaccine trials:** This is a public health law which requires that the consent of a volunteer must be obtained and the implication of the drug and vaccine trial be made known to them before the drug or vaccine trial is conducted. A breach of this law could lead to serious civil litigation that would result in payment of damages. An example is the case of the meningitis vaccine trial by Pfizer in Kano which resulted in some death and has become a subject of protracted litigation between the victims and Pfizer on the one hand and the Kano State Government and Pfizer on the other hand.

**Noise pollution law:** It was initially targeted at factories to ensure that the noise they generate does not cause hearing problems to their staff. However, the noise pollution law is now wider in scope and covers generation of noise from industries, commercial outfits, households, sporting areas, recreational facilities, generating sets, vehicles and even construction sites. It empowers government agencies involved in environmental regulation, individual and
communities to monitor and report any noise level that has exceeded 85 decibel. The law also requires industries to have and install pollution control monitoring and control unit, and where possible outsource these services to ensure compliance. It is regulated by the Factory Decree of 1987, Federal Environmental Protection Agency Decree of 1992 and the National Environmental Protection Pollution Abatement Industries and Facilities Generating Waste Regulation of 1991 (section 2).

**Law regulating the manufacture, production, distribution and sale of drugs, food and food products:** This law requires that drugs, food and food products must be wholesome and safe for human consumption from the point of production to the point of retail and consumption. For example, it is an offence to expose food and food products that human beings would consume. It also states that drugs must be manufactured to ensure compliance with set standards. The laws regulating food and drugs in Nigeria include the NAFDAC Decree No 15 of 1993 which expanded the 1974 Food and Drugs Decree No 35 and the Standard Organization of Nigeria (SON) Act, 1971 amended in 1984.

**ENFORCEMENT OF PUBLIC HEALTH LAWS**

Enforcement is the process of bringing any person who has committed an offence to attend or answer the charge against him/her before a competent authority, tribunal or court for the purpose of determining his/her innocence or guilt and to give appropriate sanctions. Enforcement procedures may vary, depending on the requirements of different environmental laws and related implementing regulations. Enforcement of public health laws refers to the various ways public health rules or regulation are complied with and the sanctions that could be imposed on an offender if found to have breached a public health law. The process for enforcing public health laws is slight different from normal criminal enforcement procedure. While criminal procedures begin in most cases with either an arrest or a summons, in public health law the procedure begins with an inspection, abatement notice, summons and arrest where necessary.
Procedures for enforcement of Public Health Laws

Inspection
This is the statutory duty of the Local Government Authority and other Environmental Protection Agencies to carry out regular inspection of premises, streets and industries, measure the level of pollution from time to time and determine what action they should take in the performance of their functions under the relevant laws establishing them. The main purpose of inspection is to detect the presence of statutory nuisances and to take steps to remove them or recommend areas of improvement. For example inspection of slums that require clearing, drainages and gutters that requires cleaning, over grown weeds, refuse dump sites, and general housing conditions to ensure they are safe and fit for human habitation.

Before an inspection is undertaken, adequate notice has to be given to the occupiers of the residence or the industry or locality within which the inspection is to be carried. This is to both serve the requirement of the law and to avoid action for trespass. At the end of the inspection a report stating the major findings must be made available to the Chief Health Officer of the Local Government who is acting on behalf of the council to take a decision on the next steps. An ideal inspection report must contain the following: the address of the premises or area, the name(s) of the inspector(s), the date of inspection, the name of the tenant(s) or occupant(s), the name of the landlord if different from the occupant, the date of commencement of the present tenancy if it is a rented premises, the rent, the rates, number of persons staying in the household, the official number of persons permitted for this type of household, a general description of the premises or the area, detailed report about the conditions of the house e.g. bathroom, kitchen, toilet, living room, heating and cooling systems, bedroom, roof, the floor, ventilation, conditions of the wall, the paints. This is followed by comments and the name and signature of the head of the team.

There could be a re-inspection report if a notice of abatement has been issued and at the end of the period given the inspector goes back to assess conditions. In this case the report would not be as
detailed as the first. However, it must still contain the address, name of inspector, date of inspection, and name of tenant and landlord. The body of the report is preferable in tabular form with the left side headed Details of inspection (with dates), and the right side headed Details of re-inspection (with dates). The entries on the left side describe the state of affairs as at the last inspection, while the entries on the right side are to state whether the issues are still present or not. It is the report of the inspection that sets the stage for the next line of action; the issuance of an abatement notice.

**Abatement Notice**

The next step in the enforcement of public health laws is issuance of an “Abatement Notice”. Once the inspector has submitted his report and the local government health authorities are satisfied that there is existence of statutory nuisance, an abatement notice must be served on the persons occupying the premises or living within the vicinity asking them to remove the nuisance. An abatement notice can be defined as a notice issued under the authority of the Local Government Council by a person so authorized to do so informing an occupant of a inspected premises or area of the existence of some nuisance which needs to be removed. It also states the details of the nuisance, the steps required to remove it, and the time within which to remove the said nuisance.

The notice must be served on the appropriate person, depending on the nature of the nuisance to be abated, but it is usually on the person whose act, omission or default has led to the existence of the nuisance. However, where such a person cannot be found then the notice is to be served on the occupier(s) or the owner of premises. In case of nuisances arising from structural defects the notice is to be served on the owner of the premises or his lawful attorney or agent. It is also important you know that a statutory abatement notice can only be served while the nuisance is still in existence. Where the nuisance has already occurred and it is likely to reoccur or has occurred repeatedly in the past, a prohibition notice should be served.
There are several forms an abatement notice may take. It may either be a repair notice, improvement notice or slum clearance notice. Whatever the form of notice it must be given 24 hours before a Health Inspector can exercise the right of entry. It is also necessary to issue the proper notice and have the proper authorization before a Health Inspector exercises the right of entry. Otherwise, if he is prevented from entering the premises the occupants would not be guilty of obstruction, rather the health inspector may be guilty of unlawful entry and trespass. However, while the proceedings for the enforcement of an abatement notice still subsist the Local Government Council or the relevant enforcement agency may still take other measures to ensure the abatement and prevention of the recurrence of the conditions that have led to the existence of the nuisance.

**Summons**

The Local Government Health Authority or other enforcement agencies may commence proceedings at the Magistrate Court where a prohibition notice has been served but not complied with following the recurrence of a statutory nuisance. Proceedings at the Magistrates Court for Public Health offences are criminal in nature. They maybe for non-compliance with abatement or prohibition notice, obstruction of officers on duty, refusal or neglect to completely abate a nuisance. Proceedings are commenced by laying information before the Magistrate who examines the facts so disclosed in the information sheet. If satisfied that there is a prima facie case against the accused a summons would be issued against the accused and served on him to appear to answer the charge(s) on a particular day, place and time.

A summons is therefore a written order by a magistrate or any judicial officer so authorised by law notifying an individual that he has been charged with an offence and requiring him to appear in court or a police station at a particular date and time (not less than 48 hours after the service of such summons) to answer to the charge or allegation against him. In the case of public health offences the summons always requires the person to appear before the court.
Summons is usually issued for misdemeanors and breach of Local Government bye-laws and it is equivalent to an arrest warrant. A breach of summons or disobedience of summons is a criminal offence and is regarded as contempt of court with a summary trial.

Furthermore, in public health offence proceedings, the prosecution is the Local Government Authority represented by a health officer such as the health inspector or/and the chief health officer/medical officer of health and not the police or a lawyer. The charge is read out to the accused and his plea taken and then the Local Government Authority health officer(s) would open the case against the accused by stating the facts of the offence and the particular section of the public health law that the accused has breached. The defendant would then have the right to cross examine witnesses if any was called by the prosecution and state his own case. The prosecution just like in regular criminal proceedings has no right of final address but may ask questions to clarify facts and argue on the point of law.

PUBLIC HEALTH LAWS ENFORCEMENT BODIES
These are government agencies, institutions or parastatals charged with the responsibility of enforcing public health laws at federal, state and local government levels.

Federal Enforcement Bodies

1. Federal Environmental Protection Agency (FEPA)
Their functions include:
- Enforce through compliance monitoring, the environmental regulations and standards on noise, air, land, seas, oceans and other water bodies other than in the oil and gas sector;
- Ensure that environmental projects funded by donor organizations and external support agencies adhere to regulations in environmental safety and protection;
- Enforce environmental control measures through registration, licensing and permitting Systems other than in the oil and gas sector;
• Conduct environmental audit and establish data bank on regulatory and enforcement mechanisms of environmental standards other than in the oil and gas sector;
• Create public awareness and provide environmental education on sustainable environmental management, promote private sector
• Compliance with environmental regulations other than in the oil and gas sector and publish general scientific or other data resulting from the performance of its functions; and
• Carry out such activities as are necessary or expedient for the performance of its functions.

2. National Environmental Standards and Regulations Enforcement Agency (NESREA). This agency has several functions and powers including:
• Prohibit processes and use of equipment or technology that undermine environmental quality
• Conduct field follow-up of compliance with set standards
• Take procedures prescribed by law against any violator subject to the provision of the Constitution of the Federal Republic of Nigeria, 1999,
• In collaboration with relevant judicial authorities establish mobile courts to expeditiously dispense cases of violation of environmental regulation;
• Issue environmental regulation

In exercise of these powers, since its inception in 2007, the agency has issued eleven regulations which include:
1. National Environmental (Pollution Abatement in Mining and Processing of Coal, Ores and Industrial Minerals) Regulations, 2009
2. National Environmental (Sanitation and Wastes Control) Regulations, 2009
3. National Environmental (Pollution Abatement in Chemicals, Pharmaceuticals, Soaps and Detergent Manufacturing Industries) Regulations, 2009
6. The National Environmental (Wetlands, River Banks and Lake Shores Protection) Regulations, 2009
7. The National Environmental (Watershed, Hilly, Mountainous and Catchment Areas) Regulations, 2009

3. The National Agency for Food and Drugs Administration and Control (NAFDAC)
NAFDAC was established by Decree No. 15 of 1993. It is an agency of the Federal Ministry of Health, with the mandate to regulate and control quality standards for foods, drugs, cosmetics, medical devices, chemicals, detergents and packaged water either imported or manufactured locally and distributed in Nigeria.

The mandate of NAFDAC in accordance with the enabling laws, includes to:
- Regulate and control the importation, exportation, manufacture, advertisement, distribution, sale and use of regulated products.
- Conduct appropriate tests and ensure compliance with standard specifications.
- Undertake appropriate investigation of the production premises and raw materials of regulated products.
- Compile standard specifications, regulations, and guidelines for the production, importation, exportation, sale and distribution of regulated products.
• Control the exportation and issue quality certification of regulated products intended for export.
• Establish and maintain relevant laboratories for the performance of its functions.
• Ensure that the use of narcotic drugs and psychotropic substances are limited to medical and scientific use only.
• Undertake the registration of food, drugs, medical devices, bottled water and chemicals.
• Undertake inspection of imported regulated products.
• Pronounce on the quality and safety of regulated products after appropriate analysis

4. The Standards Organization of Nigeria (SON)
The Standard Organization of Nigeria (SON) is the sole statutory body that is vested with the responsibility of standardizing and regulating the quality of all products in Nigeria. Established by the General Yakubu Gowon military regime through Act 56 in 1971, it was originally called the Nigerian Standards Organization (NSO). The Act establishing the body was amended in 1976 by the military regime of General Olusegun Obasanjo, in 1984 by Major General Muhammadu Buhari and again in 1990 by the regime of General Ibrahim Babangida. In 1990, the amendment of the Act conferred autonomy on the SON from the Ministry of Industry.

The statutory functions of the SON are as follows:
• To investigate the quality of facilities, materials and products in Nigeria, and establish a quality assurance system, including certification of factories, products and laboratories
• To ensure reference standards for calibration and verification of measures and measuring instruments
• To compile an inventory of products requiring standardization
• To foster interest in the recommendation and maintenance of acceptable standards by industry and the general public
• To develop methods for testing materials, supplies and equipment, including items purchased for use by State and Federal departments and private establishments
• To register and regulate standard marks and specifications
• To undertake preparation and distribution of standard samples
• To establish and maintain laboratories or other institutions, as may be necessary for the performance of its functions
• To advise State and Federal departments of Government on specific problems relating to standards
• To sponsor appropriate national and international conferences
• To undertake research as may be necessary for the performance of its functions
• To use research facilities, whether public or private, according to terms and conditions agreed upon between the organization and the institutions concerned.

5. Federal Courts (Federal High Court, Court of Appeal and the Supreme Court)
Their primary duties are to determine whether a public health law has been breached and mete out relevant punishment. They also determine issues relating to environmental pollution, civil matters dealing with compensation, damages and nuisance.

PUBLIC HEALTH LAWS ENFORCEMENT BODIES AT STATE LEVEL
Some of the Public health laws enforcement bodies at the state level include: the State Ministry of Health, State Environmental Protection Agency, the State Environmental Sanitation Authority, the Housing and Property Development Authority, the State Capital Development Authority and the Courts (Magistrates and State High Courts). Most of their functions are similar to those of the federal bodies.

Public Health Law Enforcement Bodies at the Local Government Level
The Local Governments do not have independent bodies like at the federal and state levels. For example, the Environmental Health Unit of the Local Government Primary Health Care Department has the responsibility of enforcing environmental health laws at the local government level. Some of the federal and state level bodies have branch offices at local government level which complement the role
of the Environmental Health Unit. Some the powers of the Environmental Health Officers or Health Inspectors include but are not limited to the following:

- Inspect premises in the community on a regular basis
- Determine the existence of pollution
- Determine the existence of nuisance
- Inspect industries to determine level of compliance with environmental health standard
- Serve abatement and other notices to ensure the prompt removal of statutory and other nuisances
- Determine whether any environmental health law is being or has been breached.
- Prosecute offenders
- Write reports of inspections
- Inspect meats and other food products meant for human consumption among other functions.

PUBLIC HEALTH LEGAL REMEDIES
There are legal remedies available to a victim of environmental pollution or harm. A victim of environmental harm or threat is any person who has or is likely to suffer environmental harm or threat through the activities of others. These remedies include; injunction, compensation, damages, action for loss of profit, abatement and sensibility claims.

Injunction
One of the remedies available to a person who has suffered, is likely to suffer or is continuously suffering from environmental harm or threat is to apply for an injunction against the polluter to prevent him from continuing the actions that led to the environmental harm or pollution or threat. It is an order of the Court usually a High Court restraining the defendant from continuing the actions complained of by the plaintiff in the suit. However, to succeed in an action for injunction the plaintiff must have a strong case against the defendant.
Compensation
Another remedy available to a victim of environmental pollution or harm is an action for compensation for damages suffered as result of the defendant’s action which led to the pollution. Usually, compensation actions are more appropriate if negligence is established. It has not been successfully applied in case of nuisance and trespass. Compensation is usually for damages to property and chattels and not personal injury suffered.

Damages
Equally a victim of environmental pollution or harm or threat can action for damages suffered. Damages may be exemplary or specific or general. Exemplary damages has very limited success in environmental health actions, however, where the plaintiff can prove that the defendant undertook the act because he calculated he could make profit that would outweigh the cost of damages he is to pay then exemplary damages could be awarded. General damages may also be awarded for destruction of property and personal injuries where there was negligence, but not for economic loss.

Loss of Profit
A victim of environmental pollution or harm can action for loss of profit and it is availed the plaintiff once damage has been proven in a nuisance action. It is not for any other damages but purely for economic loss.

Sensibility Claim
This is a remedy available to a person who has suffered very severe and persistent nuisance as result of environmental pollution which has resulted in some permanent loss. If the plaintiff cannot prove serious, severe and permanent loss of amenity then the damage to be awarded might not be too high.

Abatement
A victim of environmental pollution could action for abatement of the nuisance caused by the action of the defendant. This is an action in which the plaintiff is seeking an order of court to compel the
defendant to remove the nuisance he caused. This is very common in cases of public nuisance where the relevant environmental law enforcement agencies have refused or neglected to take steps to abate the nuisance.
5. ETHICS IN MEDICAL RESEARCH

A. R. NTE

INTRODUCTION
Medical research is an indispensable part of medical practice because it contributes to improvement in the quality of health care. However, because of its associated potential risks, compliance with ethical guidelines is mandatory to guarantee the safety and best interests of research subjects. Furthermore, in all settings, the physician is bound by several Declarations of the World Medical Association which include the Declaration of Geneva (Helsinki Declaration 2013 revision) which states that the health of my patient will be my first consideration and the International Code of Medical Ethics (2006 revision), which states that a physician shall respect local and national codes of ethics and shall act in the patient’s best interest when providing medical care. The Helsinki Declaration (2013 Revision) also requires of physicians who are involved in medical research to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of personal information of research subjects. The responsibility for the protection of research subjects must always rest with the physician or other health care professionals and never with the research subjects, even though they have given consent (paragraph 9). It (paragraph 10) also expects that physicians must consider the ethical, legal and regulatory norms and standards for research involving subjects in their own countries as well as applicable international norms and standards. It further warned that No national or international ethical, legal or regulatory requirements should reduce or eliminate any of the protections for research subjects set forth in this Declaration. Additionally the Nigerian physician is bound by the Code of Medical Ethics in Nigeria which not only upholds the above Declarations but also requires that when performing biomedical research involving human aspects, practitioners must conform to generally accepted scientific and moral principles and must obtain informed consent from their subjects and take responsibility to ensure the protection of their
integrity and confidence. Thus, local and international standards require physicians not only to conduct research involving human subjects and their various identifiable information and data but also to comply with the highest ethical standards which shall ensure the participants safety and best interests. It is therefore pertinent for all researchers undertaking research involving human subjects to acquaint themselves with national and internally accepted ethical standards and guidelines to ensure they conduct ethically sound research.

BIOMEDICAL OR HEALTH RESEARCH
Different Codes of Health Ethics define what constitutes a research in their own settings. However, the definition by the Nigerian National Code of Health Research Ethics will be used. It defines research as a systematic investigation, including research development, testing and evaluation designed to develop or contribute to generalizable knowledge” carried out on human subjects, their identifiable materials or data. The term systematic used in the definition requires a research to have an organized, formally structured methodology to obtain new knowledge. It also requires the development of a research protocol with clearly defined objectives for the research. Some ethical guidelines prescribe a minimum content of the research protocol for submission for scientific and ethical reviews and approvals. Generalizable knowledge on the other hand expects that the knowledge obtained from the research should have a broad or general application beyond the group that participated in it. The results should be widely disseminated and applicable to other populations.

For comparison, other definitions of research involving human subjects include:
a. Definition by the Council of International Organisation of Medical Sciences (CIOMS) (2002 revision): A research involving human subjects includes:
   - Studies of a physiological, biochemical or pathological process, or of the response to a specific intervention-whether
physical, chemical or psychological in healthy subjects or patients

- Controlled trials of diagnostic, preventive or therapeutic measures in larger groups of persons designed to demonstrate a specific generalizable response to these measures against a background of individual biological variation
- Studies designed to determine the consequences for individuals and communities of specific preventive or therapeutic measures; and
- Studies concerning human health-related behaviour in a variety of circumstances and environments.

b. Definition by the United States Code of Federal Regulations: Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

c. Definition by the World Health Organisation in the Standards and Operational Guidance for Ethics Review of Health Related Research with human participants:

Research involving human participants: Any social science, biomedical, behavioural, or epidemiological activity that entails systematic collection or analysis of data with the intent to generate new knowledge in which human beings: (1) are exposed to manipulation, intervention, observation or other interaction with investigators, either directly or through alteration of their environment; or (2) become individually identifiable through investigator’ collection, preparation or use of biological material or medical or other records.

It is therefore important for researchers in different settings to understand what a research involving human subjects means in their own settings so that they can comply with the guidelines and ethical standards that govern such researches in their settings.

Types of research involving human subjects: The different biomedical researches involving human subjects include:
• Therapeutic research – these are procedures in which interventions are administered with the intent of providing direct benefit to the research participant.

• Non-therapeutic research: these are research procedures during which interventions are not administered with therapeutic intent but are only intended to answer the scientific question of the study. The participant or healthy volunteer may unexpectedly become a direct beneficiary of non-therapeutic research. The acquisition of knowledge may be of no immediate benefit to the participant or healthy volunteer.

• Intervention Research: This is an invasive research which interferes with the research participant’s mental or physical integrity. The intervention may be chemical or psychological. It may involve the removal of bodily material, the introduction of (contrast) fluids into the body or the use of a procedure or method that has not been adequately tested. Consequently it is always risky and the magnitude of the risk may be unpredictable.

• Observation Research: This type of research involves obtaining information from the participants with or without any intervention. It may be:
  o Non-invasive when it involves no risk and no interference with the mental or physical integrity of the human research subject – e.g. a questionnaire based research, collection of information from clinical records or the unlinked and anonymous examination of a specimen taken from a patient for a clinically indicated intervention, measurement or observation – e.g. samples taken for laboratory tests or radiodiagnostic images.
  o Invasive - when the mental or physical integrity of the participant is involved but involves no risks or negligible risks which are common with routine medical procedures such as blood-letting for tests. For example during such a research, slightly more sample than is required for routine medical procedure is taken to include what is required for the research.
• Clinical Research: In this research type while the participant obtains some clinical benefits from the researcher, some generalizable knowledge is obtained. The Nigerian National Health Bill 2014 defines clinical trials as a systematic study involving human subjects that aims to answer specific questions about the safety or efficacy of a medicine or method of prevention or treatment. Additionally the South African Medical Research Council’s rule of thumb to differentiate between clinical practice and research is a useful guide. It defines a clinical research as one in which the new knowledge gained is generalized or transferred to others, or presented at a scientific meeting, or submitted for publication or for a higher qualification. Examples of such research include clinical audits through the examination of patient records, observation of activities of individuals, health systems research to improve efficiency, cost effectiveness and equality in health care.

• Non-clinical Research: This involves studies that do not use patients, for example, studies in anatomy, physiology and laboratory investigations.

• Quantitative Research: This a research that focuses on concise concepts as well as on variables, and collects information under controlled conditions. It uses structured established procedures to collect information, and uses objectivity in the analysis of numerical information using statistical procedures and involves logistic and deductive reasoning. However, the investigator does not interact with the event being researched.

• Qualitative Research: Qualitative research attempts to understand human experience. It analyses thematic and narrative information. It comprises research to understand social and cultural problems, and focuses on interactive processes to collect subjective information that is not structured numerically, but intuitively. The investigator interacts with people in a sustained manner.

Minimal risk: This has been defined by the Code of Federal Regulations (USA) to mean a probability and magnitude of harm or discomfort anticipated in a research that are not greater in and of
themselves than those ordinarily encountered in life or during daily performance of routine physical or psychological examinations or tests.

The purpose of research: The World Medical Association’s Declaration of Helsinki (2013 revision) defines the primary purpose of a medical research as to understand the causes, development and effects of diseases and improve prevention, diagnostic and therapeutic interventions (methods, procedures and treatments. However, even supposedly best proven interventions must be continually evaluated through research to ensure they remain safe, effective, efficacious, accessible and of high quality. The National Code for Health Research Ethics considers a research without clearly defined objective(s) as unethical and scientifically invalid.

Research Participants:-A research participant is an individual about whom a researcher obtains data through intervention or interaction with the individual and or identifiable private information. Identifiable information can be obtained from a user’s health records (National Health Bill-Article 28 Section (1b) and human organs obtained from deceased persons for purposes of …research (Article 54 Section 1). Other related information are defined as follows:

- The intervention may involve physical procedures and manipulation of the participant’s environment.
- Interaction includes communication or interpersonal contact between the researcher and participant.
- Private information provided by research participants are those expected to be kept confidential and can be used to identify the participant.

The United States Code of Federal Regulations defines these terms as follows:

- Human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains (a) data through intervention or interaction with the individual or (b) identifiable private information.
• Intervention includes both physical procedures by which data are gathered (for example, venepuncture) and manipulations of the subject or the subjects environment that are performed for research purposes.

• Interaction includes communication or interpersonal contact between investigator and subject.

• Private information includes information about behaviour that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by and individual and by which the individual reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e. the identity of the subject is or may be readily ascertained by the investigator or associated with the information) in order for obtaining the information to constitute a research information) in order for obtaining the information to constitute a research involving human subjects.

Informed Consent:- This is a communication process between a researcher and the research participant to make the participant competent to decide whether or not to participate in a research. It is a decision to participate in a research taken by a competent individual who has received the necessary information: who has adequately understood the information: and who after considering the information has arrived at a decision without having been subjected to coercion, undue influence or inducement, or intimidation (CIOMS 2002).

The informed consent process involves:

• Giving a participant adequate information about the study
• Providing adequate opportunity for the participant to consider all options, responding to the participant’s questions
• Ensuring that the participant has comprehended this information
• Obtaining the participant’s voluntary agreement to participate, and
• Continuing to provide information as the participant or situation requires
To be acceptable, the informed consent must be valid with the following characteristics defined by the National Code of Health Research Ethics (NCHRE):

- Adequate information provided at the educational level not higher than that of individuals with at most 9 years of education in Nigeria. The content of the form is written in such a simple language that any ordinary citizen with at least 9 years of education can comprehend.
- The design of the content process must be appropriate for the type of research, expected participants, risks anticipated and the research context.
- Consent forms should not be longer than 8 pages in order to ensure comprehensibility and enhance recall of pertinent information.
- The informed consent should be documented and witnessed.

For those who are unable to comprehend the process, special provisions are made to secure consent for their participation in a research in which their involvement is inevitable. These persons include children, mentally disabled persons or the very ill. The third party who has given the consent should be able to follow the research process and withdraw the participant whenever the best interest of the participant is threatened.

Secondary use of research records and informed consent: In situations where the secondary use of research records or biological specimens may arise, secondary uses are constrained by the conditions specified in the original consent especially where the records or specimens contain personal identifiers or can be linked to such identifiers. Consequently, when such uses are anticipated, the researchers should request the permission of prospective research participants for secondary uses of the materials when necessary. The participant should be clear about the extent of such use and the conditions under which the investigator will be required to contact research participant for secondary use, the investigator’s plans, if any, to destroy or strip of personal identifiers in the records or specimens and the rights of the subject to request destruction or
anonymization of biological specimens or of records or parts of records that they might consider sensitive such as photographs, videotapes or audiotapes.

Ethics:-This is the science of criteria, norms and values for human action and conduct. It involves a reflection and analysis of morals concerning whether an act is good or bad and how it influences the basic quest for meaning, search for humanity and attempt to create a humane society. The aim of ethics is to safeguard human dignity and promote justice, equality, truth and trust.

Ethics for Health Research:-This is the enterprise that determines norms and values to guide the systematic reflection and scientific evaluation or assessment of clinical knowledge and any form of experimentation or survey, with the prime objective of promoting health care. Its primary objectives are to benefit patients, alleviate pain and to prevent suffering.

Institutional Review Board-This is an institutional board established in accord with and for the purposes expressed in a national code of health research ethics.

IRB Approval- This is the determination of an IRB that the research has been reviewed and may be conducted at an institution within the constraints set forth by the IRB and by other institutional and federal requirements.

Waiver of the oversight function of the Institutional Review Board in a Research: The criteria for the waiver of an institutional review board’s oversight function of a research involving human subjects vary from place to place. In Nigeria, the NCHRE specifies that the IRB can review and ethically approve some researches involving human subjects but will not have oversight functions during their conduct if they meet the following criteria:
1. Research conducted in established or commonly accepted educational settings, involving normal educational practices such as:
(a) Research on regular and special education instructional strategies, or
(b) Research on the effectiveness of or comparison among instructional techniques, curricula, or classroom management methods.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behaviour unless:
(a) Information obtained is recorded in such a manner that human participants can be identified directly or through identifiers linked to the participants; and
(b) Any disclosure of the human participants’ response outside the research could reasonably place the participants at risk of criminal or civil liability or be damaging to the participants’ financial standing, employability or reputation.

3. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens if these sources are publicly available (this refers to the availability of the data and not the status of the custodian of the information/data) or if the information is recorded by the investigator in such a manner that the participants cannot be identified, directly or through identifiers linked to the participants.

4. Studies that are meant to evaluate the outcome of procedures, programmes and services because they are designed to produce information leading to improvement in the delivery of procedures, programmes and services. These studies usually evaluate measures that are already in use and considered part of standard practice. The procedure may include collection and analysis of data or collection of new data but do not involve allocation into groups or randomisation.

5. Studies that are designed to evaluate or assess quality of service, programmes and procedures and formulate guidelines leading to
their improvement. They may involve the collection and analysis of some data.

6. Innovative or non-validated medical treatment- a treatment that is designed solely for the benefit of the patient but in which the ability of the treatment to result in the desired result is to some degree not proven. They are however subjected to research to obtain information about their efficacy.

7. Clinical audit, where the study is designed and conducted solely to define or judge any current care without reference to a standard. It may involve the collection and analysis of data but there is no allocation to intervention groups or randomisation and the services have been delivered before the audit is initiated.

A REVIEW OF BIOMEDICAL ETHICS CODES AND GUIDELINES

Researches involving human participants have been conducted over decades. However as a result of some ethical lapses, guidelines, codes and regulations were developed to ensure the protection of human subjects participating in research. Some of these guidelines/codes are:

The Nuremberg Code: This first of research ethics codes was promulgated in 1947 as an aftermath of the trial of Nazi physicians (The Doctors’ Trials) who had conducted atrocious experiments which involved the sterilization of over 3,500,000 unconsenting prisoners during the Second World War. The Code was designed to protect the integrity of research subjects and prevent future atrocities to them. Some of its 10-point declarations which contain the key principles that have become the backbone of research ethics are:

- Voluntary Informed consent is absolutely essential.
- Absence of coercion
- Opt-out possibility at any time during the experiment
- Scientific justification and necessity of the experiments
- Protection of the research subjects against grievous bodily harm
- Favourable risk/benefit ratio
This Code and the Helsinki Declaration are incorporated into the United States of America’s Code of Federal Regulations, Title 45, Part 46 published by the Department of Health and Human Services and titled *Protection of Human Subjects.*

**Declaration of Helsinki:** This Declaration of the World Medical Association (WMA) on Ethical Principles for Medical Research involving human subjects was adopted at the 18th WMA General Assembly, Helsinki, Finland, June 1964. It has been amended 9 times with the latest revision adopted at the 64th WMA General Assembly, Fortaleza, Brazil, October, 2013. The Declaration is expected to guide human research work by physicians and non-physicians and reiterates the need for physicians to comply with the ethical, legal and regulatory norms and standards for research involving human subjects in their own countries as well as applicable international norms and standards. However, to further protect research subjects, it declares that *no national or international ethical, legal or regulatory requirements should reduce or eliminate any of the protections for research subjects set forth in this Declaration.* The Declaration provides for extra protection for persons with diminished autonomy and urges caution on the part of the physician-researcher who enrols his own patients. The highlights of the Declaration are:

- The protection of health and rights of human research subjects
- Compliance with appropriate local and international ethical standards and norms
- The conduct of human research by appropriately qualified health workers and its supervision by such persons
- Greater access to benefit.
- Consent should be in writing. Surrogates (third party) are allowed to give informed consent on behalf of those with limited capacity for consent but they must be able to withdraw those persons from research in their best interests
- Limited use of placebo, and vulnerable groups.
- Minimisation of the risk to the environment during research
- Development of research protocol and its approval by a research ethics committee
The Nigerian Medical Association is signatory to this Declaration and therefore its members are obligated to comply with its provisions. Other countries such as the United States of America have also incorporated the contents of the Declaration into their Code of Research Ethics.

**The Belmont Report:** - From 1932-1972, over 400 poor Afro-American men with latent syphilis were followed up in the Tuskegee study in Alabama, southern United States. With its aim as determination of the natural history of syphilis, the participants were denied treatment even when antibiotics became available in the 1940s. In 1974, the National Commission for the Protection of Human Subjects of Biomedical Research was set up to investigate this atrocity. Its report, termed *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* set forth ethical principles accepted as fundamental to all researches involving human subjects. These principles are respect for persons, beneficence and justice.

**The U.S Code of Federal Regulations-Title 45, Part 46-Protection of Human Subjects:** This was developed in 1991 and revised annually. It applies to all research involving human subjects conducted, supported or otherwise subject to regulations by any federal department or agency which takes appropriate administrative action to make this policy applicable to such research. It requires:

- Prior ethics committee approval
- Documentation of informed consent
- Equitable recruitment of research participants
- Special protection for vulnerable groups
- Continuing review of approved research
- Follow up of research participants after the research

International Ethical Guidelines for Biomedical Research involving Human Subjects-prepared by the Council for International Organisations of Medical Sciences (CIOMS) in collaboration with the World Health Organisation: The CIOMS, founded under the
auspices of the World Health Organisation and the United Nations Educational, Scientific and Cultural Organisation (UNESCO) in 1949 is an international nongovernmental organization in official relations with the WHO. It was set up at a time when individual member nations of the WHO were setting up their health care systems and required assistance with the establishment of ethical guidelines for health care and research. The first guidelines developed in 1982 by the collaborative work of CIOMS and WHO aimed at indicating how the ethical principles that should guide the conduct of biomedical research involving human subjects as set forth in the Declaration of Helsinki could be effectively applied particularly in developing countries given their socioeconomic circumstances, laws and regulations, and executive and administration arrangements. It was termed Proposed International Ethical Guidelines for Biomedical Research involving Human Subjects. The document was revised in 1993 and 2002 to address some unanswered ethical issues in previous versions. The 2002 Guidelines which contains 21 guidelines with commentaries upholds the three core ethical principles of respect for persons, beneficence and justice. Other issues addressed by the Guidelines are

- Informed consent and confidentiality
- Risk/benefit assessment
- Research in developing countries
- Protection of vulnerable populations
- Distribution of the burdens and benefits
- Role of ethics committees

The revised document extended the concept of vulnerability to persons or communities with limited resources and addressed issues such compensation and access to post trial care for participants, women and pregnancy in research and the obligation of research sponsors to provide health care for participants. Due to their global applicability, the guidelines have been widely disseminated and adopted.

3.6. International Conference on Harmonization (ICH): Between 1960 and 1970, several countries had laws and regulations for
reporting and evaluating data on safety, quality and efficacy of new medical products. The non-uniformity guidelines for these reports led to the meeting in 1990 of representatives of the regulatory agencies and industry associations of the United States, Japan and Europe to form the International Conference on Harmonization (ICH), with the goal to standardize the process by which new drugs are developed, tested and brought to market. The Guideline for Good Clinical Practice (GCP) developed by the group in 1996 has been accepted as “an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve human subjects” and adopted by many pharmaceutical companies as the standard for conducting clinical trials. The guidelines require the review by an ethics committee and informed consent of participants. The major contents of the guidelines are:

- Standardized drug development and approval process
- Protocol development standards
- Review by ethics committee
- Researcher’s responsibilities
- Sponsor’s responsibilities

In 2000, the Good Clinical Practice Guideline was amended with the addition of a section on the choice of control groups and other issues related to clinical trials, addressing the scientific output which can be obtained from different types of control groups and ethical issues associated with the choice of control groups.

National Bioethics Advisory Commission (NBAC): This Commission was set up by the president of the United States in 1995 to advise on matters related to research involving human participants. In 2001, the NBAC published a report that stipulated that all research in developing countries address a local health need. Additionally, the researchers and sponsors should involve representatives of the community and potential participants throughout the design and implementation of the research. In the design of studies, researchers must justify the use of placebo and, when possible, provide members of the control group with an established, effective treatment, regardless of its local availability.
Researchers and sponsors should make efforts to ensure access to benefits for study participants and the larger host community. The NBAC also requires that informed consent process must be not only culturally appropriate, but also must minimize all coercion or undue inducement on the part of the researcher and community representatives. All participants must be free to make a voluntary decision regardless of sex, socio-economic status, or their role in culture. The Charter of the National Bioethics Advisory Commission expired on October 3, 2001.

WHO Operational Guidelines for Ethics Committees that review biomedical research (2000): The objective of the Guidelines produced by the World Health Organisation is to *contribute to the development of quality and consistency in the ethical review of biomedical research*. They are intended to *complement existing laws, regulations, and practices and to serve as a basis upon which ethics committees can develop their own specific procedures for their functions in biomedical research*. Consequently, they establish international standard for ensuring quality ethical review. They are to be used by national and local bodies in developing, evaluating and progressively refining standard procedures for the ethical review of biomedical research. They deal with all aspects of ethical review of proposals/protocols from the establishment and functioning of ethics committee to the review of the proposals/protocol, its approval and monitoring of the implementation of approved studies. It has been in use by the University of Port Harcourt and Teaching Hospitals Research Ethics Review Committees.

The Medical Research Council (MRC) of South Africa: Starting from 1977, the MRC, in recognition of the challenge of conducting ethical research in developing countries has continued to revise its ethical guidelines to reflect the situations in South African. Its five volume series of guidelines which have been revised to the 4th Edition are

- Book 1: Guidelines on Ethics for Medical Research: General principles including research on children, vulnerable groups, international collaboration and epidemiology.
• Book 2: Guidelines on Ethics for Medical Research: Reproductive Biology and Genetic Research.
• Book 3: Guidelines on Ethics for Medical Research: Use of animals in research and training.
• Book 4: Guidelines on Ethics for Medical Research: Use of bio-hazards and radiation

The MRC promotes the four principles of biomedical ethics:
• Autonomy (respect for the person, a notion of human dignity)
• Beneficence (benefit to the research participant)
• Non-maleficence (absence of harm to the research participant)
• Justice (notably distributive justice-equal distribution of risks and benefits between communities)

HEALTH RESEARCH ETHICS IN NIGERIA
In the early 1980s, the Nigerian government established the Health Ethics Committee. The Committee became dormant and in October 2005, the President of Nigeria inaugurated the National Health Research Ethics Committee (NHREC) as the apex body responsible for the provision of and ensuring adherence to guidelines that govern ethical research practice in order to ensure the protection of human research participants in Nigeria. The terms of reference of the Committee are:
• Determine guidelines for the functioning of health research ethics committees
• Register an audit health research ethics committees
• Set norms and standards for conducting research on humans and animals including norms and standards for conducting clinical trials
• Adjudicate in complaints about the functioning of health research ethics committees (HREC) and hear any complaint by a researcher who believes that he has been discriminated against by a HREC
• Refer to the relevant statutory health professional council matters involving the violation or potential violation of an ethical or professional rule by a health care provider
Institute such disciplinary action as may be prescribed against any person found to be in violation of any norms and standards, or guidelines set for the conduct of research the bill, and

Advise the Federal Ministry of Health and State Ministries on any ethical issues concerning research.

In 2007, this Committee published the National Code of Health Research Ethics which has continued to guide the ethical conduct of research in Nigeria.

After 10 years of waiting, the draft 2004 National Health Bill was passed into law in 2014. The Bill legally established the National Health Research Ethics Committee (the National Ethics Committee) (Article 33). Among the functions of the Committee are the following:

Article 33(6): The National Ethics Committee shall have power to determine the guidelines to be following for the functioning of institutional health research ethics committees, and for the avoidance of doubt, shall-

a. Set norms and standards for conducting research on humans and animals including clinical trials
b. Determine the extent of health research to be carried out by public and private health authorities
c. Adjudicate in complaints about the functioning of health research ethics committees and hear any complaint by a researcher who believes he has been discriminated against by any of the health research ethics committees
d. Register and audit the activities of health research ethics committees
e. Refer to the relevant statutory health regulatory body, matters involving violation or potential violation of an ethical or professional rule by a health care provider
f. Recommend to the appropriate regulatory body such disciplinary action as may be prescribed or permissible by the law against any person found to be in violation of any norms and standards, or guidelines, set for the conduct of research under this Bill; and
g. Advise the Federal Ministry of Health and State Ministries of Health on any ethical issues concerning research on health.

Thus, the Bill, in addition to legalising the existence of the National Health Research Ethics Committee endorsed its terms of reference, functions and membership. It further provided for the establishment of research ethics review board committees at various levels:

34 (1). Every institution, health agency or health establishment at which health research is conducted, shall establish or have access to a health research ethics committee, which is registered with the National Ethics Committee

(2) A health research ethics committee shall:

a) review research proposals and protocols in order to ensure that research conducted by the relevant institution, agency or establishment will promote health, contribute to the prevention of communicable or non-communicable diseases or disability or result in cures for communicable or non-communicable diseases

b) grant approval for research by relevant institutions, agency or establishment in instances where research proposals and protocol meet the ethical standards of that health research ethics committee; and

c) perform other functions that may be referred to it by the Federal Minister of Health

The National Health Bill requires that the conduct of research on human subjects comply with the highest ethical standards and stipulates, among other things, institutional review boards to review the ethics of research proposal and reiterated the need for informed consent in all researches in the country. It further addressed the needs of vulnerable research participants such as children in Article 32.

Following the establishment of the National Health Research Ethics Committee (NHREC), in 2006, the National Code of Health Research Ethics was produced. The Code applies to all health
research involving human subjects in Nigeria. The Code, among other things, provided guidelines on the establishment and operations of a research ethics committee and for the submission of protocols and how to obtain informed consent. The Guidelines uphold the core ethical principles of respect of persons, beneficence/non-maleficence and justice. It also prescribes other ethical principles which shall be discussed in the section on ethical principles.

Furthermore at the national level, in 2004, the National Ethics and Operational Guidelines for research on human subjects in Nigeria was produced by the joint efforts of National Action Committee on AIDS and other partners. The document was based on existing international guidelines and proposed four core ethical principles beneficence, non-maleficence, autonomy and justice.

Locally, several institutional research ethics committees have been established to review biomedical research involving human subjects. The University of Port Harcourt Teaching Hospital’s research ethics committee has existed since the 1980s to review proposals for postgraduate fellowship and other research works. The College of Health Sciences, University of Port Harcourt similarly established its Research Ethics Committee which functioned briefly between 2006 and 2010 and became dormant. In 2011, the University of Port Harcourt established its Research Ethics Committee which has produced its Standard Operating Procedures and guidelines for approving a research proposal. Similarly, the Rivers State Ministry of Health in 2012 established its Research Ethics Committee. It is therefore evident that awareness on the need to conduct ethically sound researches involving human subjects is increasing and therefore researchers should acquaint themselves with locally and internationally available ethical principles that will guide their research works.
ETHICAL PRINCIPLES IN BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS

The Declaration of Helsinki places the wellbeing of the subject over the interests of science and society. Consequently all guidelines/codes on research ethics must adopt the highest ethical standards that protect the human subject above other interests. Various ethical codes exist but because the researchers targeted by this work are mainly those who will work in Nigeria, the ethical principles we shall uphold shall therefore be those accepted by National Code of Health Research Ethics (NCHRE), the National Health Bill and the Code of Medical Ethics in Nigeria. It is however gratifying to note that all these adopted internationally ethical principles and therefore the principles are similar to those in use elsewhere.

The purpose of ethical principles: The NCHRE defines the purpose of ethical principles as:
• To protect and promote the human rights of participants and to sensitize and encourage researchers and organizations to respect participant’s rights and needs.
• To preserve and promote autonomy of the research participant through the observance of ethics, ethical values and ethical self-regulations.
• To sensitize and protect researchers who are often under pressure from various quarters.
• To improve the quality, legitimacy and credibility of research on human subjects.

The ethical principles for application in Nigeria are:

Respect for persons:
This internationally accepted core ethical principle broadly recognizes the capacity and rights of all individuals to make their own choices and decisions. It alludes to the respect of the autonomy and self-determination of all human beings, acknowledging their dignity and freedom. It is sometimes replaced by autonomy which ensures that in researches, the rights and dignity of the participants
are respected and protected. The principle of respect for persons categorizes humans into two broad groups; those who are autonomous and those with diminished autonomy who require protection.

Autonomy means that the person is capable of deliberation about personal goals and of acting under the direction of such deliberation. The respect of autonomy means giving weight to the autonomous person’s considered opinions and choices and refraining from obstructing his/her actions unless they are clearly detrimental to others. Lack of respect for autonomy involves repudiating an autonomous person’s considered judgments, denying him or her freedom to act on his or her judgments or withholding information necessary to making the considered judgment, in the absence of adequate reasons for doing so. It is however important to note that a person’s ability to make decisions matures with age and that diseases and other conditions can negatively impact on that ability. Consequently, there is a need to protect those who for one reason or the other may not be in the best position to make autonomous decisions. People whose autonomy will need to be protected under this principle are broadly classified as the vulnerable by some authors while others consider them as a special group with a subgroup included as the vulnerable.

The respect and protection of autonomy, rights and dignity of participants requires all researchers to pay attention to the following processes:

- Informed consent
- Feedback on research findings
- Non-exploitation of participants
- Privacy, anonymity and confidentiality
- Full release of necessary information about the study
- Minimization of risks and maximization of benefits
- The obligation to compensate for research-related injuries and risks
- Distributive justice
- Inclusion and exclusion criteria
- Declaration of interest
- Safety monitoring
- Mode of Multicentre studies
- Ownership, storage and transfer of biological materials in a collaborative research
- Ethical review of a research proposal
- Peer review of publications

Special groups for protection in research involving human subjects include the sick, the elderly (old), the retarded or mentally ill, children, prisoners, the impoverished and those for whom life has neglected or betrayed. Because of the risk of becoming pregnant and the danger of some research to the foetus, women and pregnant women are also a special group for protection in various forms of research. These groups are discussed briefly below:

1. Children (minors): Research in persons aged less than 18 years, should only be carried out if it involves not more than minimal risk, especially if it is non-therapeutic in nature and cannot be done except in children. It requires the informed consent of the guardian/parents and the accent of the child. Article 32 of the 2014 National Health Bill specified the conditions for involving children (minors) in research. These are: Article 32(1). Notwithstanding anything to the contrary in any other law, every research or experimentation on a living person shall only be conducted:
   a. In a manner prescribed by the relevant authority; and
   b. With the written consent of the person after he shall have been informed of the objects of the research or experimentation and any possible effect on his health

2. Where research or experimentation is to be conducted on a minor for a therapeutic purpose, the research or experimentation may only be conducted-
   a. if it is in the best interest of the minor
   b. in such a manner and on such conditions as may be prescribed by the National Health Research Ethics Committee
c. With informed consent of the parent or guardian of the minor

3. Where research or experimentation is to be conducted on a minor for non-therapeutic purpose, the research or experimentation may only be conducted –
   a. In such a manner and on such conditions as may be prescribed by the National Health Research Ethics Committee; and
   b. With the informed consent of the parent or guardian of the minor

Note: Emancipated minors- persons aged 15-18 years, though still children can give consent for their participation in research if they are parents or in the military.

Prisoners: Because of the incarceration of prisoners, it is often difficult to get their voluntary and informed consent for researches. However because of the need to carry out some researches in this group of persons, they should be allowed to participate voluntarily in researches and no form of coercion should be used to secure their consent. Individual prisoners participating in a research or refusing to do so must not experience undue advantages or disadvantages. Researches in this category of person should only be approved if the following conditions are met:

- The research cannot be conducted in any other groups of persons, except prisoners.
- The research is not of a high risk and the procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention from the prison authorities or prisoners.

In researches expected to involve prisoners, a former prisoner or a prisoner inmate should be part of review board although being in observer status, he/she cannot vote during the decision process.

• Students: Consequent on their vulnerability to academic, financial and personal pressures, efforts must be made to protect
students when they serve as research participants. Teachers and assessors should not recruit their students for research. Students involved in researches must not receive special favours as a result of such participation neither should those who decline to participate be denied their rights.

- Pregnant women: While it is important to include women of child bearing age in researches, research associated risks to the health of women during pregnancy and the health of the foetus should be carefully assessed and the women counselled and supported. Similarly, if a woman who may become pregnant during the course of a research is to be recruited, she should be adequately informed of her risk and granted access to pregnancy test and efficient contraceptive services. If a research is considered risky to the foetus, pregnant woman and women of childbearing age should not be recruited as participants.

- The Elderly: The elderly, persons aged 60 years and above, should only be involved in a research only if it cannot be conducted in other adults. Efforts must be made to ensure that elderly research participants understand the informed consent process and face no consequences for terminating their participation in the research.

- Persons in dependent relationships: Persons in dependent relationships include the following: employees and employers, wards and their guardians, supervisees and supervisors, patients and health care providers, etc. They should be protected from exploitation during a research. Their participation should be voluntary and with informed consent. They should not be not under any coercion to participate and should be allowed to withdraw from the research in their best interests whenever they choose to opt out.

- People with mental impairment: These include the mentally ill, unconscious patients, dying patients and others who for one reason or the other are considered to be mentally impaired. These persons should only be involved in researches if the research cannot be conducted in persons who can give informed consent and the research is directly beneficial to the mentally impaired either as a group or as individuals. Where it is essential
to involve the mentally impaired in research, their consent should be obtained either directly or from a well relative and their assent should also be obtained. Their refusal to participate in the research should be respected and the request for them to opt out granted.

- **Vulnerable groups:** These are people in the following categories:
  - Limited economic development
  - Inadequate legal representation and ability to enforce human rights
  - Communities facing discrimination on the basis of health status e.g. HIV infected persons, TB and leprosy patients, epileptics and others with other chronic illnesses
  - Inadequate understanding of scientific research
  - Limited availability of health care and treatment options
  - Limited ability of the individuals to provide informed consent

The term vulnerable group is sometimes applied in its broad sense in which it includes all the special groups considered above in addition to those under this category. When these categories of persons are involved in research, efforts should be made to ensure that the research is beneficial to individual members of the community or to the community as a group and that they will have access to the benefits of the research e.g. in interventions studies. There must be provision for communicating the feedback of results to the community and their identity must be protected when reporting negative outcomes of the research.

**Beneficence and non-maleficence:**
Beneficence implies that the researcher is responsible for the participant’s physical, mental and social wellbeing as related to the study. It expects that a research should contribute positively or have the potential to contribute towards the health and welfare of the people or the good of future patients. It also requires that persons be treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their wellbeing. It is the obligation of the researcher to ensure that
participants suffer no harm while the benefits are maximized with
minimization of possible harm. Beneficence is also referred to as the
principle of non-maleficence. In accordance with the Declaration of
Helsinki, the protection of the well-being of the participant is the
primary responsibility of the researcher. Protecting the participant is
more important that the pursuit of new knowledge and the benefit to
science that will result from the research.

Non-maleficence implies that the research must not cause harm to
the participants in particular and to people in general. The risks to a
research participant should be carefully weighed against the
potential benefit to him/her and the importance of the knowledge to
be gained. All pains, sufferings or discomforts associated with the
research must be minimized, carefully justified and accurately
distributed to the participants, the patients and the people in general.

**Justice:**

The principle of justice requires all persons to be treated equally. It
requires the benefits and risks of a research to be well distributed
among people in accordance with various human rights documents.
It is important that those who bear the burdens of the research should
not be denied its benefits. Thus, it is unjust to use some persons for a
research and deny them of the benefits of that research without good
reason or when a burden is imposed unduly on another person. This
principle expects the following:-

- Distribution of risk and benefit
- Equitable recruitment of research participants
- Special protection for vulnerable groups

**Relevance (Essentiality):**

A research should have relevance to the broad health and
development needs of the nation and that of the people directly
affected by it. This is in accordance with the National Code of
Health Research Ethics which stipulates that a research should *have
social or scientific value to either the participants, the population
they represent, the local community, the host country or the world in
order to justify the use of finite resources and risk exposure of some*
participants to harm. It is also expected to evaluate issues that contribute to improvement in health and meaningful knowledge which can be disseminated to all relevant stakeholders during and after the research has been conducted. The social relevance of a research can be increased by its integration with comprehensive capacity building, technology transfer and health care delivery strategies that address significant health problems and add value to local participants of research including researchers, institutions, communities and the country.

Scientific integrity/validity:-
A research is expected to have a sound methodology and a high probability of providing answers to the specific questions it has posed. The proposal must have adequate background information derived from literature review of works both in humans and animals and in laboratory settings. The research proposal and results should be open to peer-review and scrutiny. The NCHRE identified the following characteristics of an unethical research: lack of clear scientific objective(s), use of invalid methodology; an underpowered research or one which lacks equipoise (for clinical studies), or has inadequate operationalizing plans within the context of the study site; lacks plausible data analysis plan (including a specific role for a Data and Safety Monitoring Board (DSMB) in clinical trials) or biased measurement(s) of outcome(s) of outcomes.

Fair selection of participants based on the scientific objective(s) of the research:

The subject recruitment process for any research should be fair and clearly defined in compliance with all sections of the NCHRE. The inclusion and exclusion criteria for participants and the recruitment method including the selection of research sites and communities should be ethically done. Participants who are at increased risk of harm from a research should be excluded. However, participants classified among the vulnerable should not be excluded from research especially ones that will benefit them except there are clear contraindications for that exclusion. Arrangements should be made
to provide safeguards to minimize the risks of participants especially those in the vulnerable group. Furthermore, the risks and benefits of a research should be equitably distributed with communities/individual research participants also benefiting from the outcome(s) of the research especially clinical trials.

**Investigator’s competence:**
Various Codes of Research Ethics in relation to the participation of human subjects in research focus on physicians but expect that others who are involved in biomedical research involving human subjects to adopt these principles wherever the research is conducted. The Declaration of Helsinki (2013 Revision (paragraph 12) however requires that *medical research involving human subjects must be conducted only by individuals with the appropriate ethics and scientific education, training and qualifications. Research on patients or healthy volunteers requires the supervision of a competent and appropriately qualified physician or other health care professional.* The competence of a researcher is assessed by the researcher’s education, knowledge and a certification process. The researcher is expected to have compassion and empathy and should conduct the research in a technically sound environment with good mentoring. In researches involving a team of investigators, the principal researcher must ensure that the members of the team have the competence to take care of the human subjects involved in the research.

**Accountability and transparency:**
All researches must be conducted with transparency, honesty and fairness. Research records should be kept for scrutiny for up to five years and institutions that grant permissions for the conduct of a research should monitor the research process to ensure that these principles are complied with.

**Valid attempts to minimise risks and maximize related benefits:**
All research involving human subjects must include clearly defined procedures for minimizing risks to the participants while the benefits are optimized. In line with the principle of justice, there should be
favourable risk: benefit ratio within the context of where the research is being conducted.

**Ethical approval and oversight of a research:**
All research involving human subjects should be reviewed for scientific soundness and compliance with prescribed ethical principles. A research ethics committee will only approve research that meet its ethical standards including independent review of the protocol and properly documented and witnessed informed consent. The conduct of the research should also be monitored to ensure compliance with the Code of Ethics.

**CONCLUSION**
A research on human subjects may expose them to various degrees of risks. Consequently, ethical standards and guidelines have been developed/ adopted to protect human research participants from such risks or minimize them. Although there are international Codes of research ethics such as the Helsinki Declaration, different countries have their codes of ethics to guide research involving human subjects in their country. All researchers are therefore advised to consult such guidelines and comply with their provisions to ensure the research is ethically sound. The core ethical principles of autonomy, beneficence/non-maleficence and justice remain universal and should be protected in all human researches.
6. ADMINISTRATION OF LAW IN NIGERIA

A. R. GEORGE

SOURCES OF LAW IN NIGERIA
The phrase ‘source of law’ may be used in three senses. It could be used to refer to the document in which a particular rule is contained. In this sense, sources of law refer to the law report, statutes or textbook where a principle of law could be found. This is referred to as the literary sense. The phrase can also be used to refer to the historical source of a law. In this sense we can say the oath of Hippocrates made by Hippocrates the father of modern medicine as far back as sixth or fifth century B.C is the historical source of the modern day rules of professional conduct of the medical profession. Thirdly, source of law refers to the fountain of authority of the law; that is, where a particular law derives its legal validity. This is also referred to as the legal source. For example, legislation is the legal source for the law against illegal abortion. It is in this sense that we discuss the sources of law in Nigeria. There are basically five sources of Nigerian law, namely:

- Nigerian legislation
- Case Laws
- Received English Law
- Customary Law
- International Law

NIGERIA LEGISLATION
Legislation is the final product of a conscious law-making process by a competent legislative body. In a civilian dispensation, a law made by the Federal Government is called an Act while that of the State Government is known as a Law. In a military regime, on the other hand, a law made at the federal level is known as a Decree while that of a state is called an Edict. In both military and civilian dispensation, laws made by the Local Government are called bye-laws. Upon the emergence of democracy in 1999 in Nigeria and the consequential coming into force of the 1999 constitution, all military decree/edicts were deemed to be Acts of National Assembly and
Laws of the State respectively. In a civilian dispensation the constitution is the supreme law and the validity of any law is determined by reference to it.

Another category of legislation is subsidiary legislation otherwise referred to as delegated legislation. These are laws not directly made by the legislative. They are made by persons who are given powers to make them under a status. The status that gives such power is referred to as the enabling law. When such laws are properly made they have the efficacy of law. However, where there is a conflict between a subsidiary legislation and the enabling law, the enabling law takes precedence.

CASE LAW
These are also referred to as judge made laws. By strict adherence to the principle of separation of powers, judges ought not to make laws but interpret the law and adjudicate on disputes. However, the legislative draftsmen, who are the law givers, are mortals and as such may not be able to foresee all future circumstance as to make adequate provisions for such situations. Where a situation arises that is not adequately provided for there is said to be a lacuna in the law. The court when faced with a dilemma is bound to resolve the dispute between the parties by delivering a judgment. Such judgement so delivered becomes law and is binding on all future occurrences. This is what is referred to as case law.

RECEIVED ENGLISH LAW
Received English law is that part of English law that is applicable in Nigeria. English law in Nigeria consist of the common law, doctrines of equity and the statutes of general application in force in England on or before 1st January, 1990. The terms common law and equity are capable of more than one meaning. As used here, common laws refers to judge-made laws of English court which were derived from customs of the people, while equity law refers to principles of law that originated from the then chancery courts which are applied by English courts. It is based on the fact that common law and equity
are sources of Nigerian law that Nigeria courts rely on decisions of English courts as judicial precedents.

Statutes of general application are laws in force in England on or before 1st January, 1990. It means therefore, that Laws of England enacted thereafter are not applicable in Nigeria as statutes of general application. The limitation period does not affect common law and the doctrines of equity. Wills Acts 1837 is an example of a statute of general application. Some of the English enactments which would have been statutes of general application have been re-enacted as States law with minor modification. It must be noted that statutes of general application are subject to necessary formal verbal alterations without affecting the substance. Thus, “London” in English statutes would be read as “Abuja” where it applies to the Federal Government of Nigeria, and “Port Harcourt”, where it applies Rivers State. It must also be noted that where there is a conflict between the principle of common law and Nigerian legislations, Nigerian enactments prevail.

CUSTOMARY LAW
Customary law has been defined as the organic or living law of the indigenous people of Nigeria regulating their lives and transaction. It is regulatory in that it controls the lives and transaction of the community subject to it. By the provisions of S.14 (3) of the Evidence Act, for the court to apply a custom it must not be contrary to public policy, natural justice and good conscience. The court has consistently held that customs which discriminate against women are contrary to public policy, natural justice, equity and good conscience. For instance, it has been held that the Nneato Nnewi custom which disallows women to give evidence in relation to title to land is discriminatory and against the constitution of Nigeria which provide for equal right to all sexes. The custom that deprives a female child right of inheritance has also been held to be repugnant to justice, equity and good conscience.
INTERNATIONAL LAW

International law is another source of Nigeria law. It consists of International Treaties, Charters, Concordant, Convention, Declaration, Protocol etc. Helsinki Declaration of 1964, Sidney Declaration of 1980, Oslo and Tokyo Declaration are few examples on International Declaration relating to medicine. However, an International Treaty shall only have a full efficacy of law if it is enacted into law by the National Assembly.

CLASSIFICATION OF LAW OF NIGERIA

Criminal Law and Civil Law

A crime, also known as an offence, is an act or omission which is liable to punishment under any written law. This aspect of the law is known as criminal law. Civil law on the other hand, is that aspect of law that deals with wrongs which are not punishable by the state. An act may be a crime as well as a civil wrong. For instance, death resulting from a negligent surgical operation may give rise to the tort of negligence or manslaughter which is a crime. It must be stated that not all crimes are capable of giving rise to civil liability. Treason, drug offences, currency offences and a host of others are purely crimes that can give rise to civil action. There are differences between civil and criminal actions. The purpose of a criminal action is aimed at enforcement of right and compensation for breaches. In instances where an act amounts to a crime as well a civil liability, a victim has right to pursue the two actions concurrently or in the alternative. Criminal actions are instituted by the State. The Attorney-General of the Federation and the Attorney for the State, mainly through the office of the Director of Public Prosecution, prosecute for the Federal Government and the State Government respectively. Offences such as treason and illegal bunkering are prosecuted by the Federal Government. However private persons can also prosecute by obtaining a fiat of the Attorney-General.

The police also prosecute but mainly at the Magistrate Court. However, there is no law inhibiting the police from prosecuting in other courts. Other agencies that can prosecute are the Economic and
Financial Commission (EFCC) and Independent Corrupt Practices Commission (ICPC).

**Public and Private Law**
Public law is the branch of law that deals with the relationship between the arms of government. It also deals with the relationship between private individuals and the State. Constitutional law, criminal law and administrative law are in the sphere of public law. Private law on the other hand, is the aspect of law that regulates the relationship between individuals or legal personalities. Examples are company law, banking and insurance law, law of contract, law of tort, intellectual property law etc.

**International Law/Municipal Law**
Municipal laws are domestic laws which are made to govern persons within a country. International laws on the other hand are made to regulate the relationship between countries. They are mainly outcomes of international conventions or rules made by international organizations. An example of such rules is FIFA rule which regulates the sport of soccer.

**COURTS IN NIGERIA**
Courts in Nigeria are either created by the Federal Government through an Act of the National Assembly or through a State law. The courts created by the Federal Government which can loosely be referred to as Federal Courts are the Supreme Court of Nigeria, the Court of Appeal, the Federal High Court, the High Court of the Federal Capital Territory and other courts in the Federal Capital Territory. The State Courts are the State High Court, the Customary Court of Appeal, Sharia Court of Appeal, the Magistrate Court, the District Court, the Area Court, the Customary Court and the Juvenile Court.

**THE SUPREME COURT**
The Supreme Court is the apex court. It was established in 1963. Its establishment is retained under S. 230 of the 1999 Constitution. It is made up of the chief Judge of Nigeria and others justices of the
Supreme Court not exceeding twenty-one. Generally a panel of the court is constituted by five justices. The exception is when the court is sitting on a matter that involves the interpretation of the constitution. In that instance, the panel is constituted by seven members.

This Supreme Court adjudicates on appeal from the Court of Appeal. It therefore has appellate jurisdiction over the Court of Appeal. There are cases that must be commenced at the Supreme Court and no other court. The court is said to have exclusive original jurisdiction over such matters. They include disputes between Federal Government and a State; interstate cases, matters between the President and the National Assembly, State House of Assembly and National Assembly. The Supreme Court is the court of final arbiter. However, the exceptions to this are National Assembly, Governorship and State House of Assembly electoral cases. The Court of Appeal is the court of final arbiter in these cases.

THE COURT OF APPEAL
The Court of Appeal was established by Decree No 2 of 1976. Under the 1999 constitution it is provided for in Section 237. The court is made up of the President of the Court of Appeal and at least forty-nine Justices of the Court of Appeal. Three Justices sit in the Court of Appeal. The court has appellate jurisdiction over the High Court, the Customary and Sharia Court of Appeal, Election Tribunals, Medical and Dental Practitioners Disciplinary Committee. By appellate jurisdiction over the above courts we mean the Court of Appeal hear appeals from the said courts or tribunals. Presidential Election Tribunal cases commence at the Court of Appeal and ends at the Supreme Court. The court is therefore said to have original jurisdiction over those matters.

THE FEDERAL HIGH COURT
Under the 1999 Constitution, the Federal High Court is provided for in Section 247. It is constituted by the Chief Judge of the Federal High Court and such member of Judges that may be prescribed by the National Assembly.
It has jurisdiction over matters relating to:

- The revenue of the Government of the Federation;
  The taxation of companies and other bodies established or carrying on business in Nigeria and all other persons subject to Federal taxation;
- Customs and excise duties and export duties, including any claim by or against the Nigeria Customs Service or any member or officer thereof, arising from the performance of any duty imposed under any regulation relating to customs and excise duties and export duties;
- Banking, banks, other financial institutions, including any action between one bank and another, any action, by or against the Central Bank of Nigeria arising from banking, foreign exchange, coinage, legal tender, bill of exchange, letters of credit, promissory notes and other fiscal measures;
- The operation of the Companies and Allied matters Act;
- Copyright, patent, designs, trademarks;
- Admiralty jurisdiction, including shipping and navigation;
- Diplomatic, consular and trade representation;
- Citizenship, naturalization and aliens, deportation of persons who are citizens of Nigeria, passports and visas;
- Bankruptcy and insolvency;
- Aviation and safety of aircraft;
- Arms, ammunitions and explosives;
- Drugs and poisons;
- Mines and minerals;
- Weights and measures;
- The administration or the management and control of the Federal Government or any of its agencies;
- Subject to the provisions of this Constitution, the operation and interpretation of this Constitution in so far as it affects the Federal Government or any of its agencies;
- Any action or proceeding for a declaration or injunction effecting the validity of any executive or administrative action or decision by the Federal Government or any of its agencies; and
• Such other jurisdiction civil or criminal, and whether to the exclusion of any other court or not as may be conferred upon it by an act of the National Assembly;
• The Federal High Court shall have and exercise jurisdiction and powers in respect of treason, treasonable felony and allied offences.
• The Federal High Court shall also have and exercise jurisdiction and powers in respect of criminal cases and matters in respect of which jurisdiction is conferred by sub-section of this section.

In cases of enforcement of Fundamental Rights, both the Federal and State High Courts have jurisdiction. With respect to criminal matters, the Federal High Court has exclusive original jurisdiction to hear matters such as treason and treasonable felony.

THE STATE HIGH COURT
The State High Court is provided for in Section 270 of the 1999 Constitution. It is made up of the Chief Judge and such members Justices that may be prescribed by the State House of Assembly. The State High Courts sits with at least one Judge. It means therefore that more than one Judge can sit in the State High Court. In practice it is rare to have more than one Judge sitting in the High Court. The State High Court is the court with the widest jurisdiction. Excluding all matters which Federal High Court, Court of Appeal and the Supreme Court have been vested exclusive original jurisdiction it has to entertain all matters. The court also hears appeals from Magistrate court and other inferior courts.

THE MAGISTRATE COURT
Magistrate Courts are established by State laws. These laws stipulate the civil jurisdiction of the court. For instance, in Rivers State the civil jurisdiction of Magistrate Court is limited to Five Million Naira but that of Lagos State is Two Hundred and Fifty Thousand Naira. The court is constituted by a single magistrate. In the north where the magistrate is sitting in its civil jurisdiction, it is called a District Court. The Magistrate Court in its civil jurisdiction can hear actions
arising from tort, contract, debt, damages and recovery of possession within the limits of its financial jurisdiction.

It must be noted that a Magistrate Court cannot hear matters relating to the validity of a Will and claims as to title to land. With respect to criminal matters it must be stated that the Magistrate Court cannot try murder cases and armed robbery.

**THE CUSTOMARY COURT OF APPEAL**
Section 280 of the 1999 Constitution permits any State to establish Customary Court if it so desires. It is therefore not compulsory. It consists of the President of the Customary Court of Appeal and such member of judges as may be prescribed by any State law. Customary Court of appeal is also set up at the Federal Capital Territory by the National House of Assembly.

Its jurisdiction is to hear appeals from Customary Courts in civil proceedings. It also has supervisory jurisdiction over the Customary Court.

**SHARIA COURT OF APPEAL**
Sharia Court of Appeal, by the provision of the Constitution, can be established by any State that desires it. It consists of a Grand Khadis of the Sharia Court of Appeal as may be prescribed by the House of Assembly of any State. The Court has appellate jurisdiction over matters involving Islamic personal law. It is constituted by three Khadis. There is also a Sharia Court of Appeal established by the Federal Government in the Federal Capital Territory.

**ALTERNATIVE DISPUTE RESOLUTION (ADR) AND MULTI-DOOR COURT HOUSE**
Alternative Dispute Resolution (ADR) is any medium of dispute resolution other than litigation. The forms of ADR are negotiation, mediation, conciliation and arbitration. ADR could be court-connected or non-court-connected. It is court connected where the matter is referred to ADR from the court. The terms of settlement of the parties may be filed and entered as consent judgment. It is not
court connected where the parties without any recourse to court directly settle their dispute by any of the forms of ADR.

Multi-door court system is a concept used to refer to a court system that has dispute resolution avenues other than litigation. In other words a mono-door court system is one which provides litigation as the only institutionalized channel for conflict resolution. Lagos and Abuja judiciaries have multi-door court system and have established multi-door court houses. This affords the disputants an institutionalized option to elect between litigation and ADR. A multi-door court house is an ADR service providing centre that provides various forms of ADR such as negotiation, mediation, conciliation and arbitration. Parties are not bound to use the multi-door court house. They may decide to appoint arbitrators of their choice outside the court. The choice of arbitrators and venue is usually regulated by the terms of contract of the parties.

ADR has witnessed an unprecedented growth in Nigeria. This is perhaps due to its advantages over litigation. The Nigerian court system has an inherent capacity to delay cases. The system is slow. The case of Rossek V.A.C.B took eighteen years before it got to the Supreme Court. ADR is more expeditious. Other advantages are that it is less expensive, promotes reconciliation, less formal and more sensitive to disputants’ concern.

It must be stated that not all cases can be resolved through ADR. Matters whose major issue is the interpretation of a statute or instrument cannot be appropriately resolved by ADR. Ojukwu and Ojukwu have identified three natures of disputes that can be resolved by ADR to wit:
1. Contracts
2. Employment disputes
3. Compensation
7. PROFESSIONAL LIABILITIES OF MEDICAL PRACTITIONERS

A.R. GEORGE

In every profession, there are liabilities which may be incurred by members. These liabilities are shaped by the nature of work done by the members. Although they differ in some respects they are also similar in some areas. In both the legal and medical professions for instance, advertisement is viewed as an infamous and unprofessional conduct. However, the story may be different with Nigerian local movie actors who would view advertisement as their stock in trade.

There are also areas of divergence between the medical and legal profession: Where costs are incurred due to delay caused by a legal practitioner, the court can order that the legal practitioner pay such cost. This may not be applicable in the medical profession. Also, misappropriation of client’s money is viewed as serious infamous conduct in the legal profession. This may not be so regarded by the medical profession whose nature of work hardly involve handling of client’s money. In the area of professional negligence the expectation of a medical practitioner may be higher than that of a lawyer since the former deals with life.

The objective of this chapter is to look at professional liabilities of medical practitioners. A medical practitioner may be professionally liable for negligence which may be a tort or crime, manslaughter, infamous conduct in a professional respect, perjury and battery.

THE TORT OF NEGLIGENCE

Negligence has been defined by the learned Jurist Akpata JSC: (as he was then) as:

“The omission or failure to do something which a reasonable man, under similar circumstances would do, or the doing of something which a reasonable and prudent man would not do”.

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According to Justice E.O. Fakayode, it is a blameworthy mistake. A medical practitioner would be liable for negligence if in the circumstance his colleagues would say “He really did a mistake there. He ought not to have done it”. The tort has also been defined elsewhere as the breach of legal duty to take care which results in damage undesired by the Defendant to the Plaintiff. This definition underscores the salient point that intention to cause harm is not an element of the tort of negligence. The patient-plaintiff need not establish that the defendant has the intention of causing harm. Where intention to cause harm exists, the Plaintiff may take succor in other appropriate tort heads such as trespass to person.

For action of medical negligence to succeed, the following ingredients must co-exist:
1. The Defendant owes the Plaintiff a duty to exercise due care.
2. The Defendant failed to exercise due care.
3. That as a result of the Defendant/s failure to exercise due care the Plaintiff suffered injury.

We shall consider the above elements under the following headings:

**Duty of care**
The first issue that must be determined in an action of negligence is to ascertain whether the Defendant owes the Plaintiff a duty of care. There is a duty of care in any situation where it is foreseeable that the Defendant’s action or inaction could cause harm to the Plaintiff. This is succinctly referred to as the foreseeability test. It was propounded by the eminent jurist Lord Atkins in the popular case of Donohue v Stevenson when he stated thus:

“The rule that you are to your neighbor becomes, in law you must not injure your neighbor; and the lawyer’s question, ‘Who is my neighbor?’ receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would likely injure your neighbor. Who then in law is my neighbor? The answer seems to be—persons who are so closely and directly affected by my acts that I ought reasonably to have them in contemplations as
being so affected when I am directing my mind to the acts or omissions which are called in question.”

Since the action directly affects the life and health of the patient, he therefore owes the patient a duty of care to ensure that he does not cause any injury to the patient, it need not be over-emphasized that a relationship of neighbor as espouse above, exists between medical practitioner and a patient. A medical practitioner who fails to exercise the skill or act with the degree of care expected of his experience and status in the process of treating a patient would be liable for negligence.

Duty of care to a patient is not restricted to a medical practitioner. It extends to the Hospital or clinic as an entity. Thus, the organization can also be held liable for breach of duty of care. In Cassidy v Ministry of Health, a patient lost the use of some of his fingers in a hospital where he was receiving treatment due to negligence of the resident surgeon. The court held that the patient entrusted himself to the hospital, therefore the hospital is duty bound to ensure that due care is taken in treating the patient.

**Breach of Duty**

Breach of duty of care arises where a Defendant fails to exercise the extent of carefulness required in a particular circumstance. In other words, the Defendant was careless. The onus of proving this lies squarely on the Plaintiff, this leads us to the next topic.

**PROOF OF THE TORT OF MEDICAL NEGLIGENCE AND THE DOCTRINE OF RES IPSA LOQUITOR**

Literally, Res ipsa loquitor means “the matter speaks for itself”. A classical definition of the term was espoused by Erie C.J. as follows:

“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 course of things does not happen if those who have the reasonable evidence, in the absence of explanation by the defendants, that the accident arose from want of care”.
The event which gave rise to the negligence, must tell its own story and it must be clear and unambiguous story of lack of duty of care. It embraces all situations where it is obvious that the injury would not have occurred if the Defendant was not careless. Hence the phrase “the matter speaks for itself.” For the doctrine to apply, the following conditions must be satisfied:

(A) The control over the happening of such an event rest solely with the Defendant and

(B) That in the ordinary experience of mankind, such an event does not happen unless the person in control has failed to exercise due care.

Thus, where the Defendant is not in control, the doctrine cannot apply. In Morris v Winbury Whyte, the Defendant carried out an operation on the Plaintiff which involved the insertion of tubes and subsequent replacement. The tubes were originally inserted by the Defendant but their subsequent replacement was carried out by resident doctors and nurses. After his discharge from the hospital, a portion of tube was found in his bladder. The held that the doctrine of res ipsa loquitur cannot apply since the Defendant was not fully in control of the process.

Medical negligence and indeed the tort negligence can be proved by leading evidence showing the negligent act. However, there are instances where such facts may not be within the special knowledge of the Plaintiff. Cases of medical negligence are classical example of such situations. For instance, where a swab is negligently left in the abdomen of a patient in a surgical operation, the patient who is usually under anesthesia may not be able to give evidence of the surrounding facts showing that the operation was carried out negligently. In such instances, the Plaintiff may seek refuse on the principle of res ipsa loquitur. It is on this basis that the doctrine has featured so prominently in actions of medical negligence.

This plea by a patient temporarily raises a presumption of negligence against the medical practitioner and shifts the burden of proof on him to prove that he was not negligent. When this is satisfactorily
discharged by the medical practitioner, the onus shifts back to the Plaintiff to succeed, he must call an expert to controvert the Defendant. At this stage of the swing, for the Plaintiff to succeed he must call an expert to controvert the Defendant. The reason is that the Defendant – medical practitioner and his evidence is regarded as an expert opinion. The law is settled that where expert opinion is uncontroverted the court shall rely on it as proof of fact issue. A few case law illustrations may be very helpful here.

In Ojo v. Gharoro the facts are that the plaintiff – patient had the problem of child bearing. She was examined and diagnosed of growth in her womb. She was told she needed a surgical operation to remove the growth to enable her procreate. She acceded to it. At the operation, the surgical needle got broken and a particle was left in her body. She was told that the piece of needle will not constitute any danger t her since it is sterile and may work its way to the surface where it could be removed. That if she may wish to pass through the international airport, a letter will be given to her to explain why there is a needle in her body.

At the trial, the Plaintiff relied on the doctrine of re ipsa loquitor and a presumption of negligence was raised. The Defendant rebutted this presumption by leading evidence to show that the fibroid operation was successful. However, during closure of the skin layer the surgical needle got broken. Steps were taken to remove them and only one was found. It was the evidence of the Defendant the surgical needles got broken and it was also the Defendant’s evidence that the procedure for reporting such incidents was followed and a post-operative x-ray was recommended to locate the missing pin within five days.

Three expert witnesses, a radiologist and two surgeons testified for the Defendant to prove the above facts. The Plaintiff testified on her behalf as a lay person. The court held that a plea of re ipsa loquitor only raises a rebuttable presumption and upon failing to call expert opinion to controvert the expert opinion of the Defendant, the Plaintiff failed to prove her case.
In Igbokwe v. University College Hospital Board of Management.
The deceased just delivered and was admitted as an in-patient in one of the maternity wards. She was diagnosed of psychosis and was given sedatives. The staff nurse was assigned to keep an eye on her. However, this was not done and the patient left her bed and fell down a four storey building and died. The court held that res ipsa loquitor applied since the patient would not have left the ward if the nurse instructed to watch her dully kept watch over her.

Damage
It is one of the ingredients to be proved by a Plaintiff in an action of medical negligence. Where the Plaintiff fails to prove that he suffered damage the action would fail.

In Benneth v. Chelsea and Kensington Hospital Management Committee, three night watchmen after taking tea started vomiting. They went to the hospital and a nurse called the doctor incharge of casualty. He instructed that the men should go to bed and call their doctors. One of them died after five hours. It was discovered that he died of arsenic poisoning which was introduced into the tea. An action against the casualty doctor for negligence failed because even if he had been admitted by the casualty doctor he would have dies within five hours. The Plaintiff failed to establish that the death was caused by the Defendant’s act.

In assessing damages the court considers factors such as contributory negligence. Contributory negligence is basically negligence of the Plaintiff himself which combines with the Defendant’s negligence in bringing about the injury. Where this occurs, the court will consider the circumstances of the case and apportion damages. The above principle of law is provided in Section 12 of the Tort Law of Rivers State which provides that:

“Where any person suffers damage as the result of partly his own fault and partly the fault of any other person or persons…. The damages recoverable will
respect thereof shall be reduced to such extent as the court thinks just and equitable having regard to the Claimant’s share in the responsibility for the damage. [Underlined here for emphasis]

Damages claimed could be for personal injury or financial loss. Financial loss could be cost of medical expenses for curing the injury sustained. In cases of personal injury the court in accessing damages considers: (a) the financial loss resulting from the injury and (b) the personal injury involving not only pain and suffering but also the loss of pleasures of life.

DEFENCES OF CIVIL NEGLIGENCE
There are basically two defences to the tort of negligence; contributory negligence and volenti non fit injuria. For our purpose here, we shall only consider volenti non fit injuria. The principle is to the effect that a person “knowing and comprehending the danger, voluntarily exposes himself to it……. If he is deemed to have assumed the risk and is precluded from a recovery for an injury resulting there from”. The facts in Medical and Dental Practitioner Council Disciplining Tribunal v. Okonkwo are a classical example of volenti, though decided under negligence and infamous conduct in a professorial respect. The facts are that one Mrs. Martha Okorien after delivery complained of pains. It was diagnosed that she needed blood transfusion. The patient and her husband refused based on their religious belief against blood transfusion. They are members of the Jehovah Witness religious sect.

The Biblical base of their belief is found in Act 15: 28 & 29. It reads:

“it seemed good to the Holy Spirit and to us not to burden you with anything beyond the following requirements: You are to abstain from food sacrificed to idols, from blood, from the meat of strangled animals and from sexual immorality. You will do well to avoid these things”.
The Doctor told them the implication of their refusal and discharged them with a note stating the circumstance of their discharge. In the subsequent hospital they went to, they also refused blood transfusion and the patient died. The MDCN found the defendant doctor liable but the court of appeal held that the defendant doctor was not liable.

CRIMINAL NEGLIGENCE
The relevant section of the criminal code that deals with criminal negligence of medical practitioners is Section 303 and 343(1) (e) of the Criminal Code Act provides:

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

A medical practitioner cannot be charged under this section of the law since the section does not ascribe any punishment. The section is only an admonition. However, Section 343(1) (e) provides:
“(1) any person who in manner so rash or negligent as to endanger life to be likely to cause harm to any other person, (and) gives medical or surgical treatment to any person whom he has undertaken to treat; is guilty of a misdemeanour and is liable to imprisonment for one year.”

For the prosecution to succeed under this section, he must prove the following facts: (1) that the offender gave medical (or surgical) treatment to a person whom he has undertaken to treat (2) that he did so in a manner rash or negligent (3) as to endanger life or to be likely to cause harm. Rashness and negligence in this instance connotes a disregard for life and safety of the person treated.
The distinction between civil and criminal negligence is that in the later the act must be rash, reckless and in disregard for the safety of the person treated. This is not a requirement in civil negligence.

From the foregoing, it is obvious that an act that would amount to civil negligence may not amount to criminal negligence and the latitude of proof in criminal negligence is wider than civil negligence. Obviously, this is one of the reasons why litigants prefer to pursue civil actions because it will be very difficult to succeed under criminal negligence.

**MANSLAUGHTER**
Section 317 of the Criminal Code Act defines manslaughter as any unlawful killing which does not amount to murder. This definition cannot be appreciated without an understanding of the crime of murder. Murder or culpable homicide, as it is referred to under the penal code, is the causing of death of another by a person who has the intention to kill, cause grievous bodily harm or do an act or make an omission likely to endanger human life while pursuing an unlawful purpose. From a community construction of Section 316 and 317 of the Criminal Code Act, it can be said that manslaughter is the causing of the death of another without intention to kill, cause grievous bodily harm or do an act or make an omission likely to endanger human life, while pursuing an unlawful purpose.

The offence of manslaughter is broadly categorized in two; voluntary and involuntary manslaughter. Voluntary manslaughter occurs when a person intentionally kills another but the offence is, reduced from murder to manslaughter because of the defence of provocation. Involuntary manslaughter covers all other cases in which there is no intention to kill or do grievous harm where death results of gross negligence.

Death resulting from a negligent act of a medical practitioner falls into the category of involuntary because there is no intention to kill by a medical practitioner who may have caused death as a result of his negligence. For an accused to be liable for manslaughter
resulting from criminal negligence the act must be gross, wicked or reckless. The court in R. V. Bateman explained the law in the following words:

“In explaining to juries the test which they should apply to determine whether the negligence, in the particular case, amounted or did not amount to a crime, the judges have used many epithets, such as ‘culpable’, ‘criminal,’ ‘gross’, ‘wicked,’ ‘clear’, ‘complete’. But, whatever epithet be used and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and showed such disregard for the life and safety of others as to amount to a crime against the state and the conduct deserving punishment”.

In Akerele v. R., a Medical Practitioner on a tour, administered injection known as sobita to some children to cure yaws. Sobita is a drug which ought to be administered with great caution. He administered overdose to the children and some of them died. The court held that his action does not amount to gross negligence.

PERJURY
By Section 117 of the Criminal Code Act, “Any person who, in any judicial proceeding, or for the purpose of insulting any judicial proceeding, or for the purpose of instituting any judicial proceeding, knowingly gives false testimony touching any matter which is material to any question then pending in that proceedings, or intended to be raised in that proceeding, is guilty of an offence which is called perjury.”

The most important and regular professional function of medical practitioners in judicial proceedings is the rendering of expert medical evidence. This duty is a statutory one. A medical practitioner would be liable for perjury if his expert opinion was false, and he has knowledge of its falseness. In other words the mistake is not innocent.
A doctor when summoned in court to give evidence in a criminal matter is neither for the prosecution nor for the defence. He is for justice, and should give factual findings whether they are favorable to his clients. However, in practice the situation is different. It is now a common knowledge that medical practitioners come to court to give biased views tilted in favor of their client. The resultant effect is to put the court in confusion and essence of calling expert evidence, which is to assist the court, becomes defeated. This was the observation of the court in Nafiu Rabiu v. The State where the court observed as follows:

“If it was never the intention of the defence which I feel sure it was not, to confuse issues by calling so many medical doctors, who themselves never saw the body of the deceased, and who also disagreed among themselves as witnesses, it is very clear that the doctors succeeded exceedingly well in confusing the learned trial Chief Judge.”

INFAMOUS CONDUCT IN A PROFESSIONAL RESPECT

By section 16 (1) (a) of the Medical and Dental Practitioners Act, a medical practitioner can be punished for infamous conduct in a professional respect. The Act did not provide any definition of term. However, the court in Allison v. General Council Medical Education and Registration, defined infamous conduct in professional respect as:

“Where a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonorable by his professional brethren of good repute and competency.”

The five don’ts of the medical profession are Advertising, Association (with person of dubious character). Addiction, Abortion and Adultery. A breach of any amounts to infamous conduct in a professional respect. In Allison’s case (supra), the Defendant was a
registered medical practitioner. He engaged in extensive public advertisement by stating his name, address, qualification and found the conduct in a professional respect.

The statutory body that has the jurisdiction to try a medical practitioner for infamous conduct in a professional respect is the Medical and Dental Practitioners Tribunal. It is established under Section 25 of the Act. The punishment for infamous conduct in a professional respect ranges from striking out of the person’s name in the register of member, suspension and admonition.

Where an act constitutes infamous conduct as well as crime, the Medical and Dental Practitioners tribunal cannot try the offender except criminal proceeding has been brought against him. However, it must be stated that after the criminal trial has been concluded, if found guilty, the offender can still be punished for infamous conduct in a professional respect. It must be stated that the tribunal cannot try criminal matters. It is only the regular courts that can try criminal matters.

**BATTERY**

Battery is the intentional application of force on the person of another without any lawful jurisdiction. However, where the Plaintiff consents, it will not amount to batter. Therefore, failure to obtain consent from a patient before examining the patient may cause a medical doctor to be liable for battery.

However, in cases of emergency consent is dispensed with. Consent may be express or by conduct. It is express where the patient orally or in writing accepts to medical treatment or examination. For instance, there is consent by conduct where a patient opens his mouth for a dental surgeon to pull out his teeth. Consent must be obtained from the patient personally except where the patient is in a state of coma or is an infant. In these instances, consent must be obtained from his relative or guardian respectively.
In Okekearu v. Tanko the Plaintiff sustained injury on his left centre finger and went to the Defendant for treatment. The Defendant amputated the finger which permanently disfigured and incapacitated Plaintiff in handling objects. The Defendant did not obtain express consent from the patient. He carried out the amputation only on the instruction of the patient’s aunt. The court held that the patient was an adult and consent to amputate him must flow from him. The court further held that consent can only be obtained on behalf of a patient if the patient is an infant or in state of coma. Consent to carry out a surgery and amputation must be express. Most hospitals have adopted consent form which read thus:

“This is to certify that I give permission for an operation to be performed on and anesthetic administered to and that I leave the extent of the operation to the discretion of the surgeon.”

This is rather ambiguous as it does not state specifically the nature and extent of the surgery. However the MDCN has prescribed a new form for informed consent as shown in the appendix.
INTRODUCTION
A medical practitioner may in course of his practice find himself in the employ of either the Government, private sector, or own a private clinic and thereby becoming an employer of labor. It follows, therefore, that a medical practitioner may at one time or the other be an employer or an employee. For this reason, it is very expedient for every medical practitioner to have at least a working knowledge of his industrial rights and liabilities as an employee or an employer.

Labor law or industrial law, as it is sometimes called, is that aspect of law that deals with the legal rights, duties and obligations that exist between an employer and an employee. The rights of an employer and an employee are similar in all professions and employments. However, differences are mostly in the perquisites of office which are usually sharpened by the nature of the job or profession. The labor law issues to be discussed below are common to all professions. However, we shall as much as we can, lay emphasis on areas which are very relevant to the medical profession.

CONTRACT OF EMPLOYMENT
Contract of employment is defined in Section 91 (i) of the Labor Act- as "any agreement, whether oral or written, express or implied, whereby one person agrees to serve the employer as a worker." The terms master and employer are used interchangeably, likewise worker, servant and employee. The Court in Lake Chad Research Institute v. Mohammed, succinctly defined a servant as "any person employed by another to do work for him on the terms he, the servant is to be subject to the control and direction of his employer in respect of the manner in which his work is to be done."
For there to be a valid contract of employment, as in any other form of contract, there must be offer, acceptance, consideration, capacity to contract and an intention to be bound. A contract of employment is therefore not a relationship of servitude between a master and servant. An employer is at liberty to choose who he intends to employ, likewise an employee the freedom to elect who to serve. The court lacks the jurisdiction to impose a willing servant upon an unwilling master and vice versa. Imposition of an unwilling employee upon an employer would amount to forced labor, which the Constitution proscribes as a breach of the individual's right to dignity of his person. Section 34(i) (b) and (c) of the Constitution provides:

"(b) No person shall be held in slave, " or servitude: and
(c) No person shall be required to perform forced or compulsory labor:"

On the other hand, it also amounts to the violation of the constitutional right of freedom of association for a willing servant to be imposed on an unwilling master, as the employer has the unfettered right to choose who to associate with.

**TERMS OF CONTRACT OF EMPLOYMENT**

The parties to a contract employment are at liberty to decide the terms of their contract of employment and the duty of the court is to give effect to such terms, in so far as they are within the ambit of the law. Hon. Justice Karibi-Whyte JSC (as he then was), emphasized this principle when he held that:

"... law recognizes and respects the sanctity of contracts hence where panics have reduced the terms and conditions of service into an agreement, the conditions must be observed."

The courts are therefore enjoined not to import extraneous considerations into the terms of contract of the parties but strictly interpret them and give effect to the intentions of the parties.
A contract of employment should be comprehensive enough to cover issues such as: name of employer, name and address of worker, nature of employment, duration of the employment, duration of notice of termination, hours of work, holiday, incapacity to work during sickness, terminal benefits, etc. The terms of a contract of employment may be distilled from the condition of service, collective agreement, letter of appointment, work place notices and circulars, workers handbook and any other document which the worker may be referred to in course of the employment.

Parties ought to agree and put in writing then terms at the onset before assumption of duty. However, where there is no such agreement, the employer is statutorily mandated to within three months after the period of employment, forward to the employee a written statement of the contract and failure to do so makes the employer criminally liable.

COLLECTIVE AGREEMENT AND ITS ENFORCEABILITY
Section 37 of the Trade Dispute Act defines Collective Agreement as "any agreement in writing for the settlement of disputes and relating to terms of employment and physical condition of work concluded between (a) an employer, a group of employers or one or more organizations representing employers on the one hand and (b) one or more trade unions or organizations representing workers, or the duly appointed representative of any body of workers, on the other hand. "The process of arriving or attempting to arrive at a collective agreement is known as collective bargaining”.

From a combined interpretation of the meaning of Collective Agreement and Collective Bargaining, it is clear that an agreement reached by an employer of labor and a trade union or representative of workers is a collective agreement. Thus, an agreement negotiated by the Medical and Health Workers Union of Nigeria or the Nigerian Medical Association with the appropriate authority for an on behalf of its members, is a collective agreement. A collective agreement is not enforceable except it is adopted as forming part of the individual's contract of employment.
PROBATION
Probation is the "period of trial of a new employee during which the employer takes the opportunity to understudy and test the avowed skill, comportment, ability, suitability, character, skill, adaptability and dedication of the new worker." It is a period of observation as to ascertain whether the intending worker is a fit and proper person to be placed on permanent employment.

During the period of probation, the employer has the unfettered right not to confirm the appointment of the employee. In the case of Folayan v. Ondo State University, the terms of the employment were that the worker shall be placed on probation for three years. Where the employment is not confirmed at the expiration of the three years, the probation period shall be extended to six years. At the expiration of the three years, the employment was not confirmed. He performed creditably well and was adjudged to be a very good lecturer by the university authority. Within the period, he also made publications in both local and international journals. However, he was relieved of his employment few months before the expiration of six years. The court held that his employers have right to terminate his services within the probation period.

At the expiration of the period of probation, the employee is entitled to be given a letter of confirmation. However, where such a letter of confirmation is not issued the employer is deemed to have confirmed the employment.

DUTIES OF THE EMPLOYER AND THE EMPLOYEE
As earlier stated, the parties are at liberty to stipulate the terms of their contract of employment. The duties of each party can as well be distilled from the terms of their contract. Besides the duties that may be agreed upon by the parties, there are duties which are implied by operation of law. These duties are as stated below.

Duties of the employer

a. Duty to pay wages: It is mandatory that an employer pays his worker's wages. Parties ought to decide remuneration at the
formation of the contract. However. If this is not done, the master shall pay a reasonable amount. In considering what is reasonable, the court considers factors such as the prevailing rate of remuneration in a similar trade. In instances where the wage to be paid depends on the quantity of work done, the worker shall only be entitled to "as much as he deserves." In legal parlance, this is what is referred to as quantum merit.

b. Duty to provide work: The employer is generally not under any compulsion to provide work for the servant in so far as the servant is paid. There are exceptions to this: (i) where the employment is in a professional nature and the employee needed to maintain or improve his skill and professional competence by the employment, he must be provided with a job. A medical practitioner is entitled to agitate for work under an employment as of right. Other professionals that fall within this category are lawyers, architects, academicians, typists, etc. (ii) an employer must also provide work for an employee where remuneration is computed based on work done.

c. Safety of employees: An employer must ensure that he takes all reasonable steps to ensure that the worker is safe. The employer must see that the work premises are safe. He must also ensure that he provides safe working instruments. Safety equipments and gadgets must also be made available for the employees.

d. Reference or Testimonial: The employer is not under any obligation to give reference. However, where he accepts to do so, he may be liable for the content if the facts are untrue. For instance, the bearer can maintain an action for libel if the content of a testimonial is defamatory.

**Duties of the employee**

a. **Obedience:** The employee must obey and carry out all lawful instructions given to him by his employer. Willful disobedience to lawful orders is misconduct and may be a ground for dismissal. It undermines the relationship of confidence and mutuality which ought to exist between an employer and employee.
b. **Careful Service:** A medical practitioner in course of his employment must diligently carry out his duties. Negligence is ground for dismissal.

c. **Fidelity:** An employee ought to be faithful to his employer. He must not make secret profit. It is a common practice for medical practitioners to refer patients in government hospitals to their private clinics. This is an act of infidelity.

d. **Confidentiality:** An employee must keep official secrets. Disclosure of official secrets may warrant dismissal.

**TERMINATION OF CONTRACT OF EMPLOYMENT**

Termination of contract of employment is the bringing to an end the relationship of an employer and employee. It could be by agreement of both parties to terminate the contract, performance of contract, lapse of time (for example retirement) frustration or termination at the discretion of the employer. The term "termination of contract", has been confused and wrongly used with the word dismissal or summary dismissal. Both terms are not the same. They have different legal implications.

Dismissal (commonly referred to as sack) is a punitive action against gross misconduct. Where a person is dismissed, he is not entitled to notice of dismissal or salary in lieu of notice. Dismissal carries with it a social stigma and may be a ground for disqualification in subsequent employments. The acts that can give rise to dismissal are willful disobedience to lawful orders, misconduct, neglect, incompetence and other conduct incompatible with the faithful discharge of the servant's duty.

Where an employment is terminated the employee is entitled to his terminal benefits. He is entitled to terminal notices of salary in lieu of notice. Where an employer fails to comply with the agreed term as to termination of a contract, the employee can bring an action for wrongful termination.

The exercise of the employer's power to remove the employee depends on the type of contract of employment. For this purpose,
there are basically two types of contract of employment - contract with statutory flavor and ordinary contract of employment.

**CONTRACTS WITH STATUTORY FLAVOR**

A contract of employment is one with statutory flavor if its terms such as procedure for employment, discipline, termination, conditions of service are contained in a statute. The civil service, and all other government employments are contracts with statutory flavor. Their terms are usually contained in the civil service rules and the statutes creating the *statutory* body, in case of statutory corporations.

It is however not intended to suggest here that all employments by statutory bodies are contracts with statutory flavor. Employments on contract basis and other employments whose terms are not contained in statutes, though made by statutory bodies are not contracts with statutory flavor, but ordinary contracts of employment.

The procedure for removal and discipline of persons in the service, of Federal Government owned Teaching Hospitals, for instance, is provided for in Section 9(1) of the University Teaching Hospitals (Reconstitution of Boards, etc.) Act. It provides:

(i) *If it appears to the Board that there are reasons for believing that any person employed as a member of the clinical, administrative or technical staff of the hospital, other than the Chief Medical Director; should be removed from his office or employment, the Board shall require the secretary to:*

   a. give notice of those reasons to the person in question.
   b. afford him an opportunity of making representations in person on the matter to the Board; and
   c. if the person in question so requests within a period of one month beginning with the date of die notice, make arrangements
   d. for a committee to investigate the matter and report on it to the Board; and

(ii) *for the person in question to be afforded an opportunity of appearing & live and being heard by the investigating committee*
with respect to the matter, and if the Board, after Considering the report of the investigating committee, is satisfied that the person in question should be removed as aforesaid, the Board may remove him by a letter signed on the direction of the Board.”

The above laid down procedure must be strictly followed and complied with, otherwise, such dismissal would be declared null and void and the worker reinstated with all his entitlements. In the case of University of Maiduguri Teaching Hospital v. Dawa, the service of the Plaintiff was terminated on grounds of misconduct. He was not given notice of the allegation against him, for him to defend himself, neither was he invited by any authority. He was only served with a letter of termination with a direction to see the Deputy Director of Finance and Supplies for his entitlements. The court nullified the purported termination for want of fair- hearing and reinstated him.

The court has held in University of Nigeria Teaching Hospital Management Board v. Nnoli that the procedure laid down must be strictly followed. It does not “permit any discretion, variation or circumvention.” Briefly, the facts in that case are that the Plaintiff was a qualified chemist in the compounding unit of the University of Nigeria Teaching Hospital. A qualified pupil pharmacist on internship was posted to that unit. The student was not supposed to compound drugs on his own without supervision. The student compounded chloroquine on her own which led to the death of some children aged between one and four. It was discovered that the syrup compounded was more than eight times the normal dosage.

Upon interrogation, the student admitted that she compounded the syrup under the supervision of the Plaintiff. The Plaintiff was interrogated. The Defendant claimed that upon her interrogation the Plaintiff admitted supervising the student. The court held that the Plaintiffs employment cannot be terminated based on a mere interrogation. That the procedure laid down in the Act must be strictly complied with.
The procedures laid down in the above statute is only applicable to discipline and removal of staff. Where the worker is relieved of his employment for any other reason other than discipline, the procedure laid down above would not apply, In *Fakuade v. Obafemi Awolowo University Teaching Hospital Complex* Management Board, the Plaintiff was a nursing staff under the employ of the Defendant. She was queried following an investigation of a missing stainless bowl. She replied the query and received no further reply from the Defendant. Her employment was terminated. The letter of termination did not state any reason. However, at the trial the Defendant admitted that the Plaintiff’s appointment was terminated but on grounds of a retrenchment exercise. The court held that the section cannot apply since her employment was not terminated on grounds of indiscipline.

**ORDINARY CONTRACT OF EMPLOYMENT**

Ordinary contracts of employment are those whose terms are not contained in a statute. Their terms are products of consensus agreement between the parties. Besides persons under the direct employ of the government, all other contracts of employment can be said to be ordinary contracts of employment. Thus a medical practitioner in the private sector is under an ordinary contract of employment. Contrary to the position under contracts with statutory flavor, an employer reserves the discretion to terminate such an employment at will. The court cannot inquire into the reason or motive for such termination. The court does not also have jurisdiction to reinstate the employee. The reason is that the court cannot impose a willing servant upon an unwilling master.

However, where in the contract of employment, procedures are agreed upon as to termination of the contract, the employee: can maintain an action for wrongful termination if the procedure is not complied with: Under such an action, the employee is only entitled to damages. The quantum is what he would have earned if the contract was properly terminated from the date of the termination and nothing more.
In the case of **Chukwumah v. Shell Petroleum Nigeria Ltd.**, the Defendant terminated the appointment of the Claimant, a medical doctor, who was in their employ as a medical officer. One of the terms of the contract of employment was that he is entitled to two months’ notice of termination. One of the reliefs claimed was compensation for loss suffered as a result of the Defendant's activities. The court held that he was only entitled to salary in lieu of notice as the said notice was not issued to him, and not compensation for loss. The Plaintiff was held to be only entitled to the terminal benefits in the contract and nothing more.

In a situation where it is provided, in an ordinary contract of employment, that the employee would be given fair-hearing before he is dismissed, a breach of such procedure would render a dismissal null and void as in the case of contracts statutory flavor. In such instances, the employee can only bring an action for wrongful dismissal and be entitled damages if any.
9. MEDICAL RECORDS AND THE DOCTOR-PATIENT CONTRACT

O. J. ODIA
D. ABBEY

MEDICAL RECORDS
Medical records are collections of information or data generated in the process of attending to patients. Hospitals, Clinics, Physicians’ Offices, usually keep such records. Medical records provide documentation of a patient’s medical history and are useful in the continued care of patients and for research purposes. They also contribute to the data base or vital statistics of disease occurrences in a given state or country.

However, they also serve as legal documents in the case of law suits. They can be subpoenaed by law courts and medical disciplinary tribunals. It is in the interest of the patient and doctor that accurate medical records are kept. The commonest form of medical record is the patient’s case note or folder. Records can also be kept in the form of computer tapes, discs and microfilms.
Medical records should include the following:-

Demographics
This is the section for patient’s identification and location. This includes the Patient’s full names, Identification or Hospital number, Date of Birth, Telephone number, Full address, Occupation, Next of Kin, Marital Status etc.

Medical history
This is a systematic chronicle of the Patient’s presenting complaints, past medical history, surgical, obstetrics history and immunizations. In the case of children, the growth and developmental milestones are documented.

Physical examination
Details of findings on physical examinations should be kept in a systematic manner
Provisional diagnosis and plan for management
This should be appropriately documented and outlined for easy future reference. The results of investigations, and prescriptions should be documented in the folder or case notes.

Progress or continuation notes
This should be clearly marked with time and dates. The attending Physician should sign all records in the progress notes including orders given out to subordinates.

Photographs
Photographs may be taken where necessary but kept in a confidential manner in the Patient Medical Records.

Discharge notes
Discharge notes or summaries should be clearly written. Termination of treatment or discharge prescriptions or advice should be recorded.

In case of discharge against medical advice, patients who are competent to do so should be asked to sign such discharges after the risks have been clearly explained. In the case of infants and incompetent patients, the guardian or legal representative is made to sign.

OWNERSHIP OF MEDICAL RECORDS
The laws governing the ownership of medical records are not well articulated in Nigeria. However, as a general principle, medical records are the property of the health facility that generated the record. Although the health institution owns the documents, the patient owns the information contained in the documents. Thus there is a dual ownership of medical records; the health institution on the one hand and the patient on the other. Patients have rights to see their own records. However the doctor may withhold certain information in the medical records from a patient in order to protect the patient from mental or emotional distress. In the United
Kingdom where there is national health insurance scheme, the ownership of medical records is vested in the department of health.

CORRECTIONS OF MEDICAL RECORDS
Entries in medical records must be accurate as possible and devoid of ambiguity. No deliberate inaccuracies or entries to distort the facts are permissible. Changes in or mutilation of records are usually condemned by the medical regulatory body and the law courts. In the case of corrections of entries, the entry to be corrected is crossed out with a single line and initiated by the person making the correction.

STORAGE OF MEDICAL RECORDS
Medical records should generally be stored for as long as possible. The laws governing the minimum duration of storage of medical records varies from one country to the other. In the United Kingdom it is for a minimum period of 7 years. However, for medico-legal and research purposes, medical records may be required at any time even long after the patient has died. The records should therefore be kept indefinitely. The Medical records were very useful in the prosecution of Dr Harold Shipman, accused of serial murders of his patients in the United Kingdom.

MEDICAL RECORDS CONFIDENTIALITY
Medical records are confidential documents and the privacy of the patient must be protected. Therefore such records are not usually released to a third party without the written consent of the patient or the patient’s legal representative. In the case of a law suit the records can be released if subpoenaed by the court. In the event of a court subpoena, the doctor should inform the patient in writing that his or her medical records have been subpoenaed by the court and therefore released.

Modern technological tools may be used to record, maintain and transfer information and this poses a threat to confidentiality. Therefore one must be careful not to carelessly leave copies of patient’s record in Fax machines, photocopiers and Computers.
RELEASE OF INFORMATION IN MEDICAL RECORDS
Despite the need for confidentiality, medical records can be released in the following circumstances:

**Referral to another health facility**
The patient does not necessarily have to sign a consent form for referral or summary of the medical history to be sent to a referral medical practitioner.

**Use in a court of law**
As already stated, this is usually done when a subpoena is issued by a court of competent jurisdiction. In this case a patient’s written consent does not apply.

**Insurance claims**
A patient’s consent for specific information to be released is usually required for such transactions.

**Informed consent**
Informed consent should be obtained without duress or coercion. The proposed mode of treatment, the risks involved any alternative methods of treatment or procedure and the risk of refusal of treatment should be explained to the patient.
The patient has the right to receive all available information regarding treatment and procedure. Only adults of sound mind are competent to give informed consent. The following cannot give informed consent.
1. Minors with the exception of emancipated minors and married minors
2. The mentally incompetent. Courts may be required to declare such persons insane or under the influence of hard drugs.
In emergency situations, lack of informed consent may not debar a medical procedure from being done in good faith to save the life of the patient. This falls within the premise of the Good Samaritan doctrine applicable in many countries.
Medical reports
Medical practitioners are sometimes required to give evidence in court as expert witnesses and the reports they give may be based on the medical records they have kept in the case of a patient they have examined or managed in any form in the course of their practice.

Sometimes the report relates to the findings on post mortem examinations. Forensic pathologists are frequently expert witnesses in law courts.

It is advisable to write accurate and detailed medical reports. Any medical practitioner that writes a medical report may be required by law to defend it in court, under cross examination.

A medical report that is presented to a court of law without the appearance of the author in court to defend it may not be admissible by the court. Such a report may however, be admissible when it is used for the purpose of contradicting any other evidence of the author.

NEED FOR ADEQUATE RECORDS

The medical records are strictly for the ease and sequence of continuing care of the patient and are not a member of the profession. Practitioners are advised to maintain adequate records on their patients so as to be able, if such a need should arise, to prove the adequacy and propriety of the methods, which they had adopted in the management of the cases.

MDCN code of ethics in Nigeria 44 2004 pg 53
THE DOCTOR/PATIENT CONTRACT AND MANAGED CARE

The physician/patient contract is a simple contract which does not require being in writing. It is usually implied by the conduct of the parties. It is also a unilateral contract because consideration only flows from the patient who gets the actual performance in return i.e treatment.

The doctor is under a duty of care to the patient to ensure that the patient is well treated, for instance an ophthalmologist who operates on a patient, negligently causing an injury during the operation will be liable to the patient for the breach of an implied term in his contract with the patient to take reasonable care.

Lord Wrights in Northwestern utilities Ltd v London guarantee & Accident Co. Ltd said “the degree of risk involved if the duty of care should not be fulfilled”. The greater the risk, the greater the amount of care required.

The doctor is expected to at least show the average amount of competence normally possessed by members of his profession. As such, a surgeon performing an operation is expected to display the amount of care and skill usually expected of a normal, competent member of his profession.

MDCN code of medical ethics in Nigeria 19 2004 pg 26

INFORMED CONSENT

In the process of clinical encounter, the physician or dental surgeon may need to conduct, by physical approach or invasive means certain investigations, procedures or therapeutic maneuvers on the patient. In such a situation, it is imperative and considered as good to obtain some form of formal consent from the patient. The professional manner of relationship universally distinguishes situations of good practice from what may otherwise amount to an assault on the patient. This further enhances the protection of fundamental rights of the patient.

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THE PATIENTS’ RIGHTS AND RESPONSIBILITIES
There are some rights conferred on the patients by the constitution under the fundamental human rights provision for example:

The Right to Life
Section 33 (1) of the Nigerian Constitution provides as follows: “Every person has a right to life and no one shall be deprived 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”. By virtue of this provision, the Physician is put under an obligation to take reasonable care of his patient. He must ensure that necessary precautions are taken to prevent the loss of life; otherwise he could be guilty of manslaughter or murder if it is found his negligence contributed to the death of the patient or that he deliberately did something that caused the death of the patient.
CONFIDENTIALITY

The following principles will apply when a registered practitioner is faced with disclosure of information other than for treatment of the individual patient. Information about patients is requested for a wide variety of purposes including education, research monitoring and epidemiology, public health surveillance, clinical audit, administration and planning. Every practitioner has a duty to protect patient’s privacy and respect their autonomy. When asked to provide information, a doctor should follow the following principles, that is:

- Seek the patient’s consent to disclosure of any information whenever possible, whether or not you judge that the patient can be identified from the disclosure.
- Anonymise the data where unidentifiable data will serve the purpose.
- Keep disclosures to the minimum necessary.

In practice, adherence to the ethic of confidentiality embraces:

(a) Protection of patient’s medical records;
(b) Release of information only following the granting of informed consent by the patient except where disease notification is required by statute.
(c) Cryptic utilization of anonymised clinical materials for teaching or publication in professional journals.
(d) Maintenance of confidentiality in the process of further consultation.
(e) Clear advice to patients on the breach of confidentiality which will necessarily be attendant on their consenting to undergo medical examination for the purpose of employment, insurance, security or determination of legal competence.
(f) Discretionary breach of confidentiality to protect the or the community from imminent danger.
(g) Judicious balance between maintenance of confidentiality for an under-aged patient and simultaneously making available necessary information to the parent or guardian.
(h) Breach of medical confidentiality in a court of law upon being directed by the presiding judge, which must thereafter be done strictly under protest.
(i) Presentation of a patient at a scientific meeting only following informed consent of the patient and acceptance by the audience to maintain confidentiality.

MDCN code of medical ethics in Nigeria 44 2004 pg 53.
TERMINATION OF CONTRACT
This refers to the bringing of an end, a contract between two parties and thereby releasing them from their contractual obligation. This could happen in any of the four ways.
i. By performance
ii. By agreement
iii. By frustration
iv. By breach

By Performance
This is where both parties have completed or performed their obligation under the contract. In physician/patient contract it is when treatment has been given and the patient well.

By Agreement
The parties to a contract may agree to terminate the contract. In physician/patient contract this happens when the patient informs his doctor that he is no longer coming or that he has decided for an alternative treatment.

By Frustration
A contract is said to be frustrated when parties are automatically discharged from their obligations under the contract due to circumstances beyond their control i.e. when the basis upon which the contract was entered into no longer exists or it has become physically, commercially or legally impossible to fulfill their obligations under it. Lord Raddiffe puts it this way:
“…. Frustration occurs whenever the law recognizes that without default of either party a contractual obligation has become incapable of being performed because the circumstances in which performance is called for would render it a thing radically different from what was undertaken by the contract”
In a physician/patient contract, it can only be frustrated by the death of the patient.
By Breach
This is where a party to a contract repudiates or fails to perform his obligation under the contract such that the innocent party may regard himself as being discharged. Though the guilty party is also discharged, but will be liable to pay damages. In a physician/patient contract which is a unilateral one, since the obligation is on the doctor to treat the patient, a breach by the physician will lead to liability in damage to the patient while a breach by the patient will only lead to the physician being discharged of his obligation.

LAW OF AGENCY
Agency may be described as the relationship that exists between two persons when one, called the Principal in such a way as to be able to affect the principal’s legal position in respect of third parties to the relationship by the making of contract i.e. the agent’s action affects the principal’s rights against and liabilities towards others.

Generally the principal is jointly and severally liable with his agent for any tort committed by the agent while acting within the scope of his authority, which may either be express or implied. He will be liable if the principal expressly authorizes the agent or ratifies the conduct of the agent or if the implied authority covers the acts committed by the agent.

An agent acting within the scope of his apparent authority will make his principal liable for torts committed by him, even if his acts were prohibited by the principal or were not for the principal’s benefit provided the third party was not aware of the fact s nor warned. Thus, whatever action a doctor takes, provided it is connected with the performance of his duties as a servant, the hospital will be liable. For instance, if a doctor decides to refer or divert a patient to his private clinic and it results in fatality, the hospital will be liable if the patient was deceived. The doctor will also be personally liable for his wrongful act even if it was authorized or implied.
10. MEDICAL JURISPRUDENCE

S. O. NWOSU

Medical Jurisprudence can be referred to as legal medicine or forensic medicine. The word "forensic" means court or forum. Forum is the name given to the place where lawyers practiced in the ancient Roman Empire.

Medical Jurisprudence or Forensic Medicine combines the knowledge of law with medicine, in order to adequately provide evidence for court proceedings. This allows the court arrive at the truth or nearest to the truth based on observed facts of the expert medical witness. All branches of medicine have their own forensic components. Medical jurisprudence usually relies on findings relating to detailed and precise descriptions and recording of facts and observations of patients or subjects.

AUTOPSY

Autopsy refers to post-mortem examination of the body to determine the cause of death. Other reasons for autopsy include education, research and medical audit purposes. Doctors trained in anatomical pathology or morbid anatomy, are best suited to carry out autopsies. A forensic pathologist is a sub-specialist in the area of histopathology and morbid anatomy and is trained in investigation of possible natural and unnatural causes of death.

However, any qualified and registered medical doctor can perform an autopsy or examine a patient for medico- legal purposes, and maybe required to give evidence in court as a pathologist and expert witness. It is therefore imperative for medical officers to have a good working knowledge of forensic medicine or medical jurisprudence, in other to be credible in court and positively serve the cause of justice.

Unnatural causes of death come under the jurisdiction of the coroner and include the following:-
1. Violent deaths (Homicides, Suicides, Accidents).
2. Suspicious deaths.
3. Sudden unexpected deaths
5. Death of prisoners.
6. Death of persons under the care of an institution.
7. Death possibly associated with illicit drugs and alcohol.
8. Surgical deaths.
9. Brought in dead cases.
10. Physician unable or unwilling to issue death certificate.
11. Where there is suspicion of public health threat.

MEDICO-LEGAL INVESTIGATIVE SYSTEM
There are generally two types of investigative systems in cases of unexpected, unexplained and violent deaths:
1. Pure medical investigation without judicial enquiry.
2. Judicial enquiry in the courts whether in public or in private.

Judicial enquiry in open court, presided over by the coroner, is the method that is used in Nigeria and was inherited from English legal system.

Medical investigation is the method of enquiry used in Countries with medical examiner system such as in the United States of America. Judicial enquiry in private is the method of investigation in many European countries.

CORONERS SYSTEM
In Nigeria, coroners are lawyers. Magistrates are ex-officio coroners. The police are the coroners' officers to whom cases are reported.

Cases are notified to the coroner in four ways.
1. Notification by the emergency services, or agencies in the case of accidents and unexplained sudden collapse and death.
2. The registrars of birth and deaths may report some cases either because the cause of death shown on the certificate does not correspond to the official list of possible causes of death or, because the doctor has not seen the patient for a period in excess of 14 days prior to death (this operates mainly in England).
3. Some cases are referred to the coroner by registered medical practitioners. These include deaths from overdose of drugs, death on the operating table, and death within 24 hours of admission to hospital where the cause of death is not known.

4. The general public reports cases of suspicious deaths and deaths which they think are caused by negligent behaviors of the medical attendants or health care providers.

Coroners' officers take histories of the circumstances of these cases and report the facts to the coroner. The coroner then orders for a post mortem examination to establish the exact cause of death.

If the death was from natural causes, the coroner would close the case by issuing the coroner's certificate of cause of death. In cases where the cause of death is not a natural disease, the coroner has to hold an inquest. An inquest is a hearing in open court where all evidence is taken on oath, and where interested parties have right of representation. Inquests are held either with a jury or without.

The inquest is to enquire into the circumstances of a person's death and record certain facts namely;

a) Identity of the deceased established by evidence on identification by a relative, or a friend or sometimes by means of finger prints.

b) Direct evidence is taken as to the place and date of death.

c) The pathologist who performed the autopsy will be called to give evidence as to the cause of death.

d) The coroner must record the circumstance (manner) in which the deceased came by his fatal condition. This is usually referred to as the verdict.

The verdicts which can be recorded include:-

a) Accidental (vehicular, domestic and industrial)

b) Misadventure legally identical with 'accidental death resulting from medical treatment.'

c) Suicide

d) Murder

e) Manslaughter

f) Infanticide
g) Industrial diseases
h) Neglect of self or others
i) Chronic alcoholism
j) Poisoning
k) Open verdict where there is no evidence as to the circumstances of death.

Once the verdict has been recorded, there is no way of getting it changed without going to the high court.

PROCURATOR FISCAL SYSTEM
This is the medico-legal investigative system in Scotland and it is similar to what operates in the European continent. The procurator fiscal performs both the function of the coroner and the director of public prosecutions.

Cases reported are similar to those in the coroners system. The procurator fiscal investigates the cases in conjunction with the police, forensic experts and any other experts deemed necessary. If autopsy is required a petition is sent to the sheriff who grants the warrant and a doctor is appointed to perform the autopsy. In all murder cases the autopsy is performed by two pathologists. The pathologists do the dissection together and submit separate reports to the Procurator fiscal.

In all cases the procurator fiscal makes private enquiries from all persons deemed necessary before finally certifying the deaths.

Public enquiries akin to the coroner's inquest are only conducted in cases of deaths resulting from industrial accidents. The inquiry is before the sheriff and jury of seven.

THE MEDICAL EXAMINER SYSTEM
The medico-legal investigative system operates in most of the states of America. The chief medical examiner is a civil servant and is required to be a registered medical practitioner. The chief medical examiner appoints assistant medical examiners who are scattered all over the state.
There are two types of assistants; those who do autopsies and those who do field investigations. When cases are reported to the medical examiners, the assistants who do not do autopsies go to investigate; if they are satisfied that death was from natural cause, they issue a death certificate. If not satisfied, the body is taken to the mortuary and the assistant who is a pathologist examines it. Then the police are called to the location. If autopsy examination says death is due to a natural cause, the police retire but if it is a crime the police will continue with the necessary procedures.

**THE DOCTOR AND THE LAW**

Doctors become involved in legal actions in the following ways:

1. As the defendant is either a criminal or civil action. This may have nothing to do with their medical activities.
2. A witness in a legal action, appearing to provide information or opinion to assist the legal process.

**Witnesses are of three types;**

1. An ordinary witness' or a "witness as to fact". This has nothing to do with medical practice.
2. A "professional witness" where the doctor gives some purely factual evidence of something he did or saw during his medical work.
3. An 'expert witness' is a specialist or medical officer who assist the law by giving an expert opinion on certain facts, even if he has no knowledge of the particular circumstance.

All medical witnesses have to give oral testimony in court. The evidence may be in the form of a written statement or deposition which is accepted as documentary evidence.

There are two criminal procedures: Adversarial and Inquisitorial.

**THE DOCTOR IN COURT**

1. The first stage is making a statement (may be an affidavit or sworn statement this makes it legally acceptable in court).
2. The doctor is invited to court either through a printed witness
order delivered or mailed to his address or a more formal method of issuing of a subpoena, which is a court order signed by a judge or other official. This must be obeyed or the doctor will be charged with contempt of court.

3. When the medical witness is called, he will be asked to go to the witness-box or stand and will be required to take the oath where he will promise to tell the truth.

4. If called by the prosecution, the lawyer will question him based on earlier presented report. This is called examination-in-chief. Then the defense lawyer will rise to "cross-examine' the doctor and attempt to weaken those parts which are damaging to his client.

Following the cross-examination, the prosecutor has the opportunity to re-examine but must only ask question which clarify anything which was discussed in cross-examination.

**The Behavior of a Doctor in Court**
1. The doctor should be very conversant with the content of his report since this will form the basis of what he will give orally.
2. The doctor should appear as a serious and authoritative person.
3. His demeanor and dress should reflect the professional image.
4. Evidence should be given in clear, firm voice, it should be loud enough.
5. He should not be over-talkative, but neither should he be monosyllabic to the point of rudeness.
6. Must never become hostile, angry, rude or sarcastic during questioning.
7. The doctor should gently resist the command to answer with simple yes or no since in many medical or scientific matters, an answer requires an explanation.

In summary, the medical witness in court should "dress up", “stand up”, “Speak up” and “Shut up".
MEDICAL REPORTS AS EVIDENCE IN COURTS
Medical reports may constitute evidence in a Court of law and the author will be required to defend it in court. As stated earlier, the medical officer must have a good or working knowledge of forensic medicine in order to appropriately serve the cause of justice.

Outlined below are some conditions that the doctor may have to handle for medico-legal reasons.

WOUNDS
A wound is a disruption of the continuity of the skin or mucosal surface caused by physical force. Any doctor may be relied upon to examine a person who has suffered a wound, whether the patient is alive or dead, whether the injury is trivial or severe, whether the cause is an accident, suicide or homicide. Such an examination may have serious medico-legal importance. It is therefore necessary that before treatment commences, a thorough examination of the wounds must be carried out, in anticipation of legal complications either at the time or at a later date.

A "wound" and an "injury" are not distinguishable by law. The word "wound" suggests that the lesion was deliberately used while an "injury" could arise from any cause, including pure accident. 'Assault' in law is the threat of an attack; the actual attack is termed battery.

Medical reports on wounds
These include;
1. Correct definition of the various types of wounds on the body.
2. Accurate and permanent record of the findings - direction, dimension, in order to do justice to patient and the judicial system.

Classification of Wounds

Abrasions (Scratch or graze)
This is confined to the epidermis and is not serious or life - threatening. It is the most informative of all injuries and always
reflective of impact. It often indicates the causative object or surface and direct of impact.

The definition of abrasion includes:
1. A portion of the body surface from which the sub-mucous membrane has been removed by rubbing.
2. A superficial injury of the skin not involving the thickness of the skin (confined to epidermis papillary dermis, or body lining epithelium, usually to blunt force, except in a scratch.)

All abrasions are caused by either of two mechanisms:
1. Loss or scrapping of epidermis or dermis by tangential friction or rough surface (graze or sharp point scratch).
2. Superficial crushing of epidermis or dermis caused direct impact. These are often seen in fatalities.

Imprint Abrasion: The causative object may stamp its shape or surface pattern on the skin e.g. rope weave 'in hanging or ligature in strangulation, whip, tyre tread in Road Traffic Accidents, bite marks (double crescents of spaced linear impression) fingernail on neck in throttling.

Tangential Impact: Direction of impact can often be assessed; starting edge has beveled descent; a series of parallel furrows indicate direction the sliding motion, finishing edge has tags of heaped epidermis.

Bruises (contusion. ecchymosis)
This is defined as leakage of blood from ruptured small vessels (veins and arterioles) into the surrounding tissues. Bruises are caused by blunt injury to the tissues which damage blood vessels. Hemorrhage or bleeding is the escape of blood from part of the vascular system. Bruising may be seen in skin, muscle or any internal organ.

Blood usually leaks in a diffuse manner, spreading along 1 planes. Therefore, the site of bruising does not necessarily reflect site of trauma. For example:
• A blow to temple can cause bruises on cheeks.
• A fractured jaw may show bruising on necks and a fractured hip may underline bruises on the thigh.
• A bruise may have a delayed appearance on body surface. Deep bruising may take up to 24 hours to appear at the surface.

**Age and Color Change in Bruises:**
The time course is very variable and depends on adequacy of lymphatic and venous drainage, size and depth of bruise, anatomical site, age of person (very slow in the elderly) and general health. Distinguishing fresh from old bruise is easier and more important particularly in repeated assault. The color change is as follows:

Dark red (color of capillary blood) to densely purple, then brown and later green, 4-5 days or more, yellow 7-10 days or more, straw and disappears in 14-15 days.

**Classical Patterns of Bruising**
1. **Patterned Intradermal Bruise:** This is usually to impact with a hard, patterned object with ridge, may be grooves. Skin over ridges is compressed and vessels remain intact. Skin is forced into grooves and dermal vessels rupture. The resulting accumulation of a small amount of blood, near the epidermis may demonstrate the obvious pattern of the casual surface (tyres, shoe tread, car bumper, clothing, gun muzzle).

2. **Finger-pad Bruises:** They are round or oval, slightly longer than the finger tips due to outward spread of blood. It is due to gripping by fingertips in forceful restraint. This may be found on:
   • Limbs and face (child abuse)
   • Thighs (rape)
   • Neck (throttling, that is manual strangulation)
   • Arms (forceful restraint or post mortem movement of the body)

3. **Tramline Bruises:** This is due to a rod shaped weapon or stick. Compression of vessels occurs centrally and not usually damaged unless crushed onto bone. Traction causes rupture of vessels along edges of rod.
4. **Doughnut Bruise**: This is due to a spherical object like a cricket ball or love bite with no teeth marks; suction bruise caused by firm application of the lips against the skin, forming an air-tight seal. Oral suction causes a shower of petechial bruises.

5. **Laceration**: This is defined as full thickness tearing of the skin or other tissue due to stretching, pinning and crushing of tissues by blunt force. Pinning, crushing, and stretching forces result in splitting and tearing of tissues. These are the types of trauma which cause bruising and abrasions. Soft tissue areas of limbs may be lacerated by a blunt projecting object which pulls obliquely against the tension of the skin causing stretching and tearing. Rolling and grinding movement of a vehicle wheel strips and tears the tissues.

**Lacerations are characterized by:**
1. Ragged Edges (torn apart), bulging fat, crushed hair bulbs.
2. Associated bruising and abrasions of skin edges and adjacent tissue.
3. Tissue bridges in depth of wound (intact nerves, vessels, tendons)

Laceration may often cause little external blood loss, except of the scalp due to crushing and retraction of vessels. There may be associated internal injury or bleeding, wound infection may occur due to foreign bodies. Frequently, laceration may heal by scarring.

**Incised Wound (Cuts, Slashes)**
This is a clean division of the full thickness of skin or other tissues under the pressure of a sharp-edged instrument. An incised wound is longer than it is deep due to swipe action. If the instrument is sharp-edged, such as a knife, it will give a clean and linear wound, if jagged metal, it will give an irregular and jagged wound.

An incision is usually characterized as follows:-
- Clean cut, everted edges
- No tissue bridges or abrasion of margins
- Liner or elliptical shape. often gape

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• Often deeper at starting and jagged if inflicted through
• Loose, folded skin.

The following are the forensic importance of incisions:-
• Reflect sharp edge, not weapon type
• No trace evidence
• Profuse external hemorrhage and air embolism
• Danger to life depends on site and depth.
• Incised wound may be self-inflicted, or due to assault or accident.

**STAB WOUND**
This is a kind of incised wound where the depth is greater than the length. They are more dangerous than slashed wounds as they penetrate deeply.

**Characteristics of Stab Wounds.**
• The wound is slit-like after removal of the knife and the centre widens making the length slightly shorter.
• The wound is rarely the size of the instrument due to elasticity of the skin and spasm of muscles.
• The size of the wound depends on the taper of the blade and the depth of penetration. It also depends on whether the knife was rocked within the wound.
• If the knife is twisted within the wound a sharp or irregular wound will result.
• Most knifes have one cutting edge and this may be reproduced.
• The depth of the wound may be longer than the knife if force is applied.
• There may be bruising and abrasion caused by the hilt.

**Defensive Wounds**
There are characteristic injuries which indicate that the victim attempted to defend himself. Where punching, kicking or attack with a blunt instrument took place, the outer side of the forearm, back of the hands and knuckles may be abraded, bruised or even lacerated.
Fingers may be broken in an attempt to shield the head and from the blow. In knife attacks, when the knife-blade is d, typical cuts are seen in the flexor surfaces of the fingers usually at the joints. Another common injury is a deep incision across the web of the palm between thumb and the finger. In kicking attacks, bruises may be sustained on the outer side of the thigh, if the victim crosses his legs to this genital region.

**Cut Throat:** Cutting and stabbing to the neck is seen in suicide and homicide. It is rarely accidental when someone falls through a window or door.

**Suicidal Cut Throat:** This is usually characterized by tentative incisions on left s' of neck if right handed or more deep, sweeping cuts, do from the left, across the mid-line, up towards the right ear cut slopes upwards and backwards. Incision is usually through the level of the thyroid ligament and may be down to the spine with repetitive nicks at the base of the wound (sawing), bleeding is venous, and loss of consciousness slow. Air embolism may occur.

**Homicidal Cuts:** This usually lies both higher and lower across the neck with the following characteristics:–
- No tentative cuts. All cuts are forceful and deeps rapidly.
- No repetition in some tracks.
- Slope backwards and downward
- Associated with defensive injuries to hands and arms.

**INJURIES IN ROAD TRAFFIC ACCIDENTS**
Injuries due to road traffic accidents can apply to pedestrians or car occupants.

**Injuries to Pedestrians**
These can be classified into:
- Primary, due to the impact of the vehicle
- Secondary, due to striking the ground or other objects.

**Primary Injuries:** These occur where an adult is hit by a car. The bumper (fender) will strike the victim at or below knee level either
in front or by the side. Further primary injury on the thigh or hip can occur due to radiator grille, lamps or bonnet. However, if the vehicle is large the primary injuries may be at a higher position on the chest, arms or head.

**Secondary Injuries:** These occur when the body is hit. It can be thrown violently away or projected up into the air and travel a considerable distance before striking the ground or other obstruction. The secondary injuries are usually lethal particularly involving the head, chest and pelvis. Skidding along the road gives rise to brush abrasions. If the pedestrian is hit on the feet, he could be scooped-up onto the bonnet or windscreen. This does not occur with large vehicles.

There could also be "running-over" injuries when the wheels pass over the body (gross distortion of head, chest, pelvis or abdomen). Flail chest may result. Where a motor wheel rotates against a body on the ground, large area of skin and subcutaneous tissue may be ripped off. This is called a flaying injury, seen most often on leg, arm or scalp.

**Injuries to Car Occupants**

Most vehicle accidents are frontal, causing severe deceleration to the car and anything contained inside, which includes the driver and passengers. Front-seat occupants if unrestrained by seat belts are thrown forwards and strike the vehicle structures in front of them. The face and head may hit the windscreen glass frame or side-pillars.

Chest may be crushed against the steering wheel causing rib, sternum, heart and liver damage. The knees may strike the parcel shelf and be injured or fractured. The legs especially those of the driver may be fractured by transmitted stress, which may also dislocate the hips and fracture the pelvis.

The head swinging violently forwards during deceleration may cause hyper flexion injury to the cervical or thoracic spine. If the head strikes a solid structure, the rebound may then cause hyper-extension injury, if no head-restraints are fitted to the seats. The momentum of
the heart within the thorax often tears the aorta. The front seat passenger often suffers worse injuries. Rear-seat passengers are also liable to injury, though not so severe as those in the front of the car. They may be thrown against the back of the front seats, projected over the front seat passenger to hit the windscreen and even be thrown out through the glass.

Motor Cycle Injuries
Most injuries to motor cyclists are due to projection from the machine into the roadway. Head injuries are common. Leg fractures and bums are also common. Chest and spinal injuries may also occur. A more unique injury is from tail-gating where the motor cyclist drives under the rear of a truck causing severe head injuries, even decapitation.

Medical Examination of Road Traffic Accidents
The doctor must always remember that examination may have legal consequences:
- Examine the patient or body thoroughly, including the clothing where available (tears, soiling by oil, grease or road dirt etc).
- Any broken glasses, paint flakers, rust or foreign material should be carefully preserved.
- All injuries should be carefully recorded with measurements: the distance of major injuries above heel level should be measured.
- Tyre marks (abrasion or intradermal bruising should be noted.)

BURNS AND SCALDS
The extent of heat-induced injury depends on:
- The applied temperature
- The time for which the heat is applied
- The ability of the body surface to conduct away the excess heat.

Five hours at 40 degrees or 3 seconds at 60 degrees will cause a burn. When the heat is dry, the result is called burn while moist heat from hot water, steam and other hot liquid is known as scalding.
Burns
Burns are classified both by severity and extent.

Classification by Severity

First degree: this is characterized by erythema and blistering. Split in epidermis and epidermal pain due to exposure of nerves, no loss of dermis, capillary dilatation, swelling and exudation. Blister surrounded by zone of hyperemia. Blister may resolve or burst, and heals with no scarring.

Second degree: This is characterized by:
- Destruction of the full thickness of skin, no pain as nerves are destroyed; epidermis coagulated or charred.
- Central necrosis surrounded by zone of hyperemia and central area slough; epidermis grows in from edges and from surrounding dermal structures.
- Scarring and contracture may occur.

Third degree: This is characterized by destruction of underlying fat, muscle, or bone. When application of heat is prolonged the tissues may be charred, carbonized or completely destroyed.

Classification by Extent
Rule of nines indicates clinical prognosis. Each arm is 9% of body area, leg 18%, anterior trunk 18%, back 18%, head 9%, and palm is 1%. Involvement of 30-50% of body surface is usually not compatible with life.

Scalds
Scalds are not accompanied by charring, carbonization or hair shrinking as seen in dry heat. These usually resemble first degree burns; red desquamated and blistered. They usually show intensely red base covered by wrinkled, macerated epidermis with swelling and exudation of serum.

EXAMINATION OF BODIES RECOVERED FROM FIRES
In examination of bodies recovered from fires the doctor should note the following:
• Not all bodies recovered from fires were burnt to death.
• Majority may have died from inhalation of smoke and noxious gases even if the bodies have later been burnt after death.
• It is difficult to differentiate ante-mortem from postmortem burns if the body is severely destroyed.

A careful search must be made for any ante-mortem injuries. The scene should be examined if possible. The position of the body may indicate that victim attempted to retreat from the advancing fire.

The color of the skin should be noted to demonstrate areas that have been protected from burns. Cherry-pink skin indicates carboxyhaemoglobin and can be confirmed by internal examination and analysis of blood.

There may be black soot particles in the nostrils and perhaps mouth; confirmed at autopsy when carbon particles are found in the larynx, trachea and bronchi.

**Causes of Death in Burns**

(a) **In rapid death**
• The actual destructive effects of heat, asphyxia or shock due to pain
• Inhalation of hot gas burning the interior of the air passages
• Carbon monoxide toxicity and other gases

(b) **When Death Is Delayed**
• Dehydration and electrolyte disturbances from plasma loss from the burned surfaces are an early cause.
• Later renal failure
• Infection of the widespread burns.

**ASPHYXIA**

Literally speaking the word "Asphyxia" denotes anoxia or hypoxia. However, in the forensic context, true asphyxia is usually obstructive in nature, as some barrier exists to prevent access of air in the lungs. Other conditions, especially neurogenic and
cardiovascular, may be the true mechanism, rather than hypoxia. Where the air passages are obstructed, a series of symptoms and signs ensues until cardiac arrest terminates the process. In many cases, the later may occur either immediately or after a short interval, so the classical features of asphyxia have no time to develop.

**The traditional signs of asphyxia are:**

(a) Congestion of the face, due to the back-up of venous drainage from congestion of neck veins or obstructed venous return into the heart.

(b) Edema of the face, due to transudation of plasma caused by raised venous pressure.

(c) Cyanosis or blueness of the skin, especially in the head and neck where neck or chest pressure is maintained. The color is due to failure of oxygenation of the venous blood, so that reduced hemoglobin is in excess.

(d) Petechial hemorrhage in the skin and eyes, especially the lax tissues of the outer eyelids, the conjunctivae and sclera and the skin of the face, lips and behind the ears.

This is due to raised venous pressure from impaired venous return and not to hypoxia of the vessel wall, as petechiae can develop long before hypoxia becomes severe.

**Suffocation**

This can either mean:

- Absence or reduction in the oxygen content of the inspired air or
- Mechanical obstruction to entry of air into the external, respiratory orifices. It is called smothering when caused by deliberate covering of the nose and mouth.

Congestive and petechial signs are almost invariably absent; as there is no element of venous obstruction. Death may be very rapid before any true hypoxia can take effect, suggesting that death is due to some neuro-chemical cardiac inhibition.
Choking
This word may mean manual strangulation but is usually applied to internal obstruction of the upper air passages. An object or substance impacted in the pharynx or larynx can lead to severe respiratory distress with congestion, cyanosis, petechiae etc. or can lead to a rapid silent death from vasovagal cardiac arrest. Rarely, such obstruction may be due to gagging during robbery so as to silence the victim. At first victim can breathe through the nose but later nasal mucus and edema close the posterior nares and progressive asphyxia develops.

Pressure on the Neck
There are three forms that are of prime forensic importance.
- Manual strangulation (or throttling)
- Ligature strangulation, and
- Hanging

Death may occur slowly with "classic" signs of congestion, cyanosis and petechiae or be rapid and even almost instantaneous due to sudden cardiac arrest, when a pale face with no classic signs may be observed. When pressure is applied to the neck, the following effects may occur:
- Obstruction of the jugular veins with impaired venous return of blood from the head to the heart.
- Obstruction of the carotid arteries which if severe, causes cerebral ischemia.
- Stimulation of the baroceptor or nerve endings in the carotid sinuses and carotid sheath.
- Elevation of the larynx and the tongue closes the airway at the pharyngeal level.

Manual Strangulation (Throttling)
This is a relatively common mode of homicide by a man against a woman, sometimes associated with sexual attack. It may be performed by one or both hands, from front or back. The grip and even the hands may be changed during the course of the attack.
The external signs are abrasion and bruises on the front and sides of the neck, often along the jaw-line. They are frequently at each side of the laryngeal prominence. The bruising may consist of disc-shaped areas about a centimeter in size. There may also be linear scratches from fingernails. Some of these may be from the assailant, but the victim may also mark her own neck in trying to push away the strangling fingers. If death is rapid, due to the probing fingers squeezing the carotid sinuses, then there may be no facial congestion, cyanosis or petechiae.

In strangulation, the larynx can be damaged. The most vulnerable structures are the superior horns of the thyroid cartilage, which can be fractured on one or both sides. One or both greater horns of the thyroid may be fractured although less commonly more rarely the cricoid cartilage is fractured. In blows to the throat, the main plate of the thyroid cartilage can be split.

Ligature Strangulation
The constricting band is tightened around the neck, usually producing gross congestion, cyanosis and petechiae in the face. If the pressure is maintained for more than 15 seconds, sudden death can supervene from pressure on the carotid baroceptors but not as frequently as in manual strangulation.

The ligature mark is a vital piece of evidence, especially when the killer has taken away the actual ligature. If the ligature is left behind, there may be vital reaction at the margins as well as petechial hemorrhage. The mark goes round the whole neck, with mark of cross-over usually above the laryngeal prominence.

Occasionally the ligature mark may be across the front of the neck, if the assailant presses front or pulls from back. There may be scratches and bruises on the neck. Internally, the same findings as in manual strangulation may be found.

Hanging
Hanging or self-suspension is a form of ligature strangulation where the pressure is produced by the weight, of the body itself. Hanging
need not be in the fully erect posture, with the feet clear of the ground, though this often happens.

Most hangings, especially the free-swinging positions, show more of the classical signs of congestion and petechiae. It is very unusual for the cervical spine to be broken in suicidal hanging except for unusual one which employs a long drop. The lesion in the hanging for judicial execution in which there is drop of several meters completely disrupts the cervical spine, sometimes at the atlanto-occipital joint, but usually in the mid-cervical portion.

Suicidal hanging usually shows a mark on the neck that does not run round the full circumference of the neck. The mark on the neck usually rises to a peak pointing to this junction. Exceptions occur if the noose is very tight, when it may dip into the skin all the way round, often because a ship-knot was used. In atypical hanging where the suspension point is low and the body leans over away from the rope, a horizontal mark may be produced which can be confused with strangulation.

**Traumatic Asphyxia**
This is the cause of death in most mass disasters due to failure of crowd control. Another cause is collapsed building. The essential feature is fixation of the thorax by external pressure, which prevents respiratory movements. The classic signs of congestion, cyanosis and petechiae are seen in their most gross form.

**Postural Asphyxia**
This is a related condition where an unconscious or stuporose person, either from alcohol, drugs or disease lies with the upper half of the body lower than the rest of the body. The inverted position allows the abdominal viscera to push up the diaphragm and this, together with reduced respiratory effort can cause death with marked cyanosis, congestion and petechiae in the face and neck.
DROWNING

Bodies recovered from water may have died from any of the following:

- Natural causes before entering the water.
- Natural causes in the water
- Exposure and hypothermia in the water
- Injuries or other unnatural causes before entering the water.
- Injuries after entering the water
- Submersion, but no drowning. This includes "shock' which is cardiac arrest due to cold water on the skin, larynx or pharyngeal area.
- True drowning after submersion, from aspiration of large volumes of water into the lungs.

The mechanism of death in bodies that die as a result of submersion is not always classical drowning.

The mode of death is cardiac arrest if the person dies quickly, sometime within seconds. This is due to a vagal inhibitory reflex triggered by a sudden stimulation of sensitive areas due to rapid cooling of the body surface or sudden in rush of cold water into the mouth and nasal passages impinging on the sensitive mucosa of the pharynx and larynx.

In true drowning, the mechanism of death includes:

- Hypoxia from deprivation of air.
- Electrolyte and fluid changes which varies according to the type of water in which drowning occurred.

Fresh Water Drowning:-

In fresh water drowning, the fluid is hypotonic compared to plasma, as there is rapid osmotic transfer through alveolar membrane. Blood volume may increase by 50% within a minute. The hypervolaemia places a great strain on the heart. Haemolysis of red blood cells occurs with hyperkalemia which contributes to rapid myocardial failure.
Seawater Drowning
Sea water is hypertonic compared to plasma. Therefore, water is withdrawn from plasma into the lungs. There is also electrolyte transfer, namely sodium and chloride into the blood. Absence of hypervolaemia that causes strain on the heart probably accounts for the longer survival period in salt water submersion.

Postmortem Findings in Drowning
This is variable. Drowning is very difficult to prove at autopsy especially when the victim's body is not examined fresh. Classically, there will be froth in the mouth and nostrils. The mechanism of death in bodies that die as a result of submersion is not always classical drowning.

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Laboratory Test for Drowning
Electrolyte estimation is not reliable. The presence of microscopic algae, which is present in sea water and uncontaminated fresh water in the tissues (kidney, brain, bone marrow) is compared with the type found in the water in which the victim is said to have drowned.

FIREARMS AND FIREARM WOUNDS
Types of firearms: There are two main types

a) Shot-guns: These are smooth-bore weapons consisting of a metal barrel which has either parallel sides or a slight taper. The open
end of the barrel is the muzzle. They are sporting guns. They are known as shotguns because they fire a large number of small spherical lead shots. They have long barrels, although they can be illegally shortened by criminals. They are two common sizes of shotguns based on their bore size. “12-bore” (19mm bore diameter) and 410 (bore diameter is 0.410 inches or 11mm)

b) **Rifled weapons (revolvers, automatic pistol rifles etc.):**
These are military weapons. They fire one projectile at a time. The barrel has spiral grooves cut into the metal, the intervening projection are called "rounds": Most rifled weapons have a mechanism for bringing a new "round' into the breach for repeat firing.

In the revolver, the cylinder rotates under trigger pressure to line up a new cartridge. In self-loading and automatic weapons, gas pressure provides the energy. The ammunition is a closed metal cylinder carrying the firing cap and propellant charge, into the distal end of which is clamped a single projectile.

**Wounds from Smooth-Bore Guns**
Hot gas, flame, smoke, propellant wads and shot contribute to the appearance of shotgun wounds. The shot pattern is a long shallow cone, the further along this cone the victim is situated the larger will be the wound pattern. Contact wound with muzzle touching the skin may cause a circular abrasion due to gas forced into the tissues pressing the skin against the metal. The entrance wound is circular and about the size of the muzzle. There will be some smoke soiling, unless the gun was pressed so tight that a good seal was made.

The tissues will be blackened inside and the surrounding area may be pink due to carbon monoxide from discharged gases. The wound edge will be regular with no pellet marks, the wad or plastic piston will be inside the wound. If the discharge is over an area supported by bone, the entering gases will rebound from the underlying bone; raise a dome of skin, then splits, so that the entry wound is ragged and irregular.
Near Discharge
Discharges within a few centimeters are similar to contact wound, though there will be no muzzle marks. More smoke soiling can occur and burning of skin, singeing and clubbing of melted hairs will be seen. Wads will be in the wound. There will also be powder tattooing due to burning flakes of propellant. These cannot be washed off as easily as smoke soiling.

Intermediate Ranges (between 20cm to 1 meter).
This is characterized by diminishing smoke soiling. Powder tattooing persists and spread of shot will begin first causing an irregular rim to the wound. This is called the rat-hole in the USA.

Longer Ranges
The shot will spread progressively at 2-3 meters, satellite pellet holes will be seen around the central wound, which diminishes in size as the range increase. The spread of shot in centimeters equals two to three times the range in meters.

Very Long Ranges (Such as 20-30 Meters)
There is uniform peppering of shot and this is rarely fatal. Shot-guns rarely produce exit wounds when fired in the chest or abdomen.

Wounds from Rifled Weapon

Contact wound:-
These are circular unless over a bony area such as head where gas rebound splitting may occur. Muzzle mark may occur if pressed hard to the skin. There may be slight escape of smoke, some local burning of skin and hair and redness of carbon monoxide staining.

Close Range (within 20cm)
This is usually a circular hole (unless discharge was at an angle). Some smoke soiling and powder bums of skin and hair may be present. Bullet hole in skin is inverted and may be slightly smaller. There is abrasion collar.

Longer Range (which may be several kilometers)
The wound is usually characterized by abrasion collar. There is no smoke soiling, burning or tattooing beyond about one meter. In
extreme ranges, the gyroscopic track is lost and the missile begins to wobble. This causes a larger, more irregular wound.

Exit Wounds
This is usually everted with slit flaps causing a stellate appearance. No burning, smoke or powder soiling where skin is firmly supported, as by a belt, brassieres or even leaning on a partition wall. The exit wound may be as small as the entrance and may fail to show a typical eversion.

Doctor's Duty in Firearm Related Injuries and Death.
It is important to take good notes of original appearance before surgical intervention. Any foreign materials within the wound should be carefully preserved for the police lead shots and bullets should similarly be preserved.

EXPLOSIVES
The causes of death or injury includes:
1. **Blast Effect:** When an explosion occurs there is generation of high volume of gas wave- which sweep outward. This results in physical fragmentation, disruption and laceration of the victim from high pressure and hot gas. There may be pressure effect upon the viscera, which are far more damaging, where an air-fluid interface exists, (air passages, lungs. alimentary canal). Rupture and hemorrhage of these zones is the classical blast lesion.

2. **Secondary Effect:** Bums, both from the effect of the explosion and secondary burns from conflagrations started by the bombs.
   - Missile injury from parts of the bomb casing and adjacent objects propelled by the explosion
   - Peppering by small fragments, debris and dust propelled by the explosion. These can cause multiple abrasions, lacerations and bruises and discolor the skin.
   - All types of injury due to collapse of buildings, roofs, ceiling due to structural damage from the explosion.
   - Injuries and death from vehicles, damages or destruction
Doctor's Duty
The medical examination is similar to that in any type of trauma. A catalogue of abrasions, bruises etc are required. If many bodies are involved, then the doctor's role includes the identification of the bodies.

SEXUAL OFFENCES
Rape: This is defined as unlawful sexual intercourse by a man with a woman; by force, fear or fraud. Unlawful means without consent, either because the woman did not give any consent at all or because her consent was invalid on account of age or mental state.

Sexual Intercourse: This means penile insertion, even if this is only just between the labia. Anything less is indecent assault. An orgasm or ejaculation of semen is not relevant, only penetration. Usually, a female cannot be charged with having forcible sex with a man, though theoretically, she could be accused of indecent assault. The meaning of force in relation to rape need not necessarily indicate physical restraint by the man, even the fear of such violence is sufficient.

Indecent Assault: This applies in a case of suspected rape where it cannot be proved by medical or other means that the penis passed between the labia. Doctors stand the risk of this accusation. This is why it is advised that there should always be a third person when a physical examination is being carried out by a doctor.

Indecent Exposure and Indecency with Children (Flashing): This is where a 'man displays his genitals in public, to the annoyance and embarrassment of women and children.

Incest: This consists of sexual intercourse between close relatives.

Homosexual offences: Sexual acts among same sex though legal in some countries, is illegal in Nigeria.
Doctor's Duty in the Examination of Sexual Offences

- Examination must be performed in good surroundings both for comfort and reassurance of the victim.
- The consent of the woman should be sort, explaining to her that whatever evidence is obtained may be used in court and that she will be exposed to publicity and cross-examination.
- There should be a third party while examination is carried out because of the intimate nature of the examination.
- A full record of the examination is essential stating time, date and place, the details of the victim, and the names of those present.
- The history should cover the events complained of, but also details of menstruation, pregnancies and sexual activity in the recent past.
- If the victim is a young teenage girl, her apparent age should be compared with her real age, and noted if she appears precocious. Her dress, make-up and manner might have misled a young man to think she was over the age of consent.
- General physical examination will include the clothing that she was wearing when the event occurred.
- The examination should start extra-genitally looking for evidence of injuries like bruises and abrasions on the neck, shoulders, upper arms, back, buttocks, thighs and legs especially if the woman had been gripped in restraint or held down on a rough surface.
- Bite marks on the neck, shoulders or breasts are significant but may also occur in consenting sexual activities.
- Blood stains, semen, mud and others including scraps of vegetation or other foreign material should be noted.
- Pubic hair should be inspected and combed out. Foreign hair mixed with victim's hair may offer a clue as to the aggressor.
- If any dried stains suggestive of semen are seen on the skin or mixed with the public hair, these should be carefully recovered for the laboratory.
Examination of the perineum

This should start with visual examination of the vulva, followed by a lower and upper vaginal swab. The anus is inspected and an anal swab taken. The ano-genital area is examined for redness, abrasions, bruises and lacerations in the following areas; labia, anal margins, vaginal introitus and vaginal wall. The presence and state of the hymen is noted for swelling, redness, tearing or bleeding. Finger nail scratches may be seen.

In all cases, where liquid is seen in the vaginal tract, it should be collected either by pipette into a small tube, or picked up on a swab. Spermatozoa can be identified from the vagina after 24 hours, and occasionally even up to 72 hours.

Enzyme and serological test for semen can be made after a much longer time both form genital tract and stained fabric. A venous blood sample, for grouping, alcohol estimation and possible DNA profile should be taken and swab for microbiological culture should also be taken.

If the woman has scratched her attacker, she may have blood or even skin tags under her fingernails, which must be carefully scraped out and sent to the laboratory for blood grouping or DNA profile, which may match a suspect later in the investigation.
11. NATIONAL HEALTH INSURANCE SCHEME

O.J. ODIA
O MADUKA

The objectives of this chapter are to afford the reader an overview of the national health insurance scheme, to explain to the reader in clear details the objectives and modus operandi of the NHIS. And to enable the reader have a working knowledge of how the scheme works with its possible legal and ethical challenges.

INTRODUCTION
A health insurance scheme is a pre-payment plan in which the insured pays a regular fixed amount to the scheme and in return is able to get health services without having to pay for the health services when required. The pre-paid sum or premium of each insured contributor is pooled by the insurance body or organization and this enables the insurance provider pay for those that need health care.

THE NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA
The NHIS which has as its primary objective, the elimination of deficiencies in the health care system of the country. In particular to positively address the issues of assess, equity and affordability.

Thus, it is supposed to make health care readily accessible and affordable to the generality of the populace.

Historical Background
The need to have a national health insurance scheme was mooted in 1962 by the federal government. However, owing to opposition from some medical unions, the idea was dropped. In 1984, the idea was resuscitated by the then minister of Health Admiral Patrick Koshoni on the advice of the National Council on Health, Professor Olikoye Ransome-Kuti, commissioned a national committee on the establishment of the NHIS. The committee recommended the capital model.
In 1989, the Federal Executive Council gave its approval and directed the federal ministry of health to start the scheme in 1993. In 1997, the scheme was formally launched and on May 10, 1999, it was finally signed into law by the then Head of State, General Abdulsam Abubakar.

The national health insurance scheme was established by decree 35 9f 1999 with the basic goal of improving health care delivery in the country. It was aimed at being a health social security system.

HEALTH CARE PROVISIONS AND BENEFITS OF THE NHIS
These include the following:
- Curative Medical Care
- Outpatient attendance
- Maternity care for up to four deliveries per insured person
- Consultations with defined range of specialists
- Hospital inpatient in a standard ward of admission limited to cumulative 15 days/per year.
- Eye examination and care not including provision of spectacles
- Dental Care
- Consultation
- Oral Examination
- Oral Preventive Care
- Pain Relief

1. Preventive Care
   - Immunization
   - Family Planning
   - Health Education

2. Drugs and Diagnosis
   Prescribed drugs and Diagnostic test as contained in the NHIS essential drug list and diagnostic test list.

3. Prostheses and Rehabilitation.
   Prostheses are limited to artificial limbs made in Nigeria.
STAKEHOLDERS AND PARTICIPANTS IN THE SCHEME
The implementation of the scheme is in phases and is for all Nigerians divided into the following categories
1. Employees in the formal sector (public or private)
2. Self-employed persons organized into co-operatives.
3. Rural dwellers: The program designed for them will be organized through Community banks, Co-operatives, Local, State and Federal Governments, donor agencies and NGO’s.
4. Vulnerable groups like the unemployed, the aged, the disabled, street children, the retarded and retirees, will be provided for by the Federal, States and Local Governments, NGO’s and philanthropists.

Contributions made by the insured, provide him or her together with the spouse and four children under the age of 18 years, access full health benefits. Additional dependants attract extra contribution is deducted from his salary.

MANAGERS OF THE SCHEME
The major managers of the Health Insurance Scheme includes the following:
1. Health maintenance organization (HMO)
2. Insurance Companies
3. Health Care providers
4. National Health Insurance Scheme management

HMO
These are the financial managers of the Scheme. Their functions include:
- Collection of Contributions from the employers and employees
- Collecting contributions from other contributors
- Payments of health care providers for services rendered
- Maintenance of quality assurance

Health management organizations are limited liability companies formed with the sole purpose of providing health services and are duly registered under the scheme.
EXCLUSIONS
The following conditions and treatment procedures are not covered by the NHIS
- Occupational and industrial injuries
- High technology investigations except in life threatening emergencies. CT Scan, MRI are partially excluded
- Transplant and cosmetics surgeries
- Provision of spectacles and contact lenses
- Provision of hearing aids and other such appliances
- Management of chronic medical conditions such as cerebrovascular disease, tuberculosis, chronic renal failure etc.
- Antiretroviral treatment for HIV/AIDs
- Infertility management
- Dentures and implants maxilla-facial surgeries
- Pap smears, PSA and mammography have partial exclusions as the HMO pay 20% of the cost of these procedures.

HEALTH INSURANCE COMPANIES
These are the registered insurance companies with the proposed role of providing health care delivery as Health insurance companies and provision malpractice insurance cover for health care providers.

Health insurance subsidiary companies can be formed by an already registered insurance company or group of companies could jointly register a health insurance company. All health care providers are required to obtain a malpractice insurance or professional indemnity insurance as a condition for registration to participate in the scheme.

All health care professionals, physicians, nurses, pharmacists, radiographers, etc are all required to possess valid professional indemnity insurance as individuals or as body corporate.

HEALTH CARE PROVIDERS
Under the National Health Insurance Scheme, health care providers are required to register in order to be eligible to participate in the provision of health services to contributors and their dependants.
Health care providers are in two categories:
(a) Primary health care providers, and
(b) Fee for service health care providers.

The primary health care providers include:
(a) Private clinics/hospitals
(b) Primary health care centres.
(c) Nursing/Maternity homes (overseen by a doctor)
(d) Outpatient departments of general, specialist and teaching hospitals.

Payments to the above Health Care Providers is by means of capitation. Capitation is a predetermined amount of money paid by HMO on behalf of a contributor for health services. This payment is made monthly whether or not services are utilized.

Fee for Service Health Care Providers
These include:
(a) Specialist doctors
(b) Pharmacists
(c) Laboratory Scientists
(d) Radiographers
(e) Physiotherapists
(f) Dentists

These specialties provide services to contributors only on referral from primary health care providers. The HMOs pay immediately for services rendered.

THE NHIS MANAGEMENT
The management of the NHIS consists of two administrative bodies:
(a) National Health Insurance Council
(b) State Health Insurance Boards

The National Health Insurance Council
This consists of the following as members:
- Chairman appointed by the Head of State on the recommendation of the Minister of Health.
Representative of the federal ministries of Health, Finance, office of the establishment and recipient services, Nigerian Employees Consultative Association, Nigeria Labor Congress, Registered Health Maintenance Organizations, Private health Care Providers.

- Two persons to represent public interest.
- Executive secretary of the NHIS is also secretary to council.

The law provides for any member of the council except ex-officio members to hold office for four year term in the first instance and may be renewed for a final term of four years. The management of the NHIS is entrusted with the powers to set standards, monitor implementation, ensure compliance, and serve as a regulatory body.

**State Health Insurance Boards**
The state health insurance board consists of a board of directors whose membership is appointed by the Governor of the state on the recommendation of the State Commissioner of Health. The general manager of the board is appointed by the board itself. The board is responsible for the general management of the scheme at the state level.

**OPERATION OF THE NHIS**
Each contributor registers with an NHIS approved HMO. The registered contributor is given an I.D Card with a personal identification number. When the contributor requires health care, the contributor goes to his chosen health care provider for treatment. A contributor has the right to change his health care provider after a period of six months.

Arbitration boards to settle disputes between participants in the scheme are to be set up in each state and should consist of representatives of the Nigeria Medical Association, Pharmaceutical Society of Nigeria, National Association of Nurses and Midwives and the general public.
ETHICAL CONSIDERATIONS
It is important for medical practitioners to ensure that ethical standards are met while accepting retainerships and capitation rates from health maintenance organizations.

They must not allow health maintenance organizations (HMO) to browbeat them into under-treating patients or engage in any activities that are inimical to the interest of the patients. According to the MDCN, “retainerships, capitations and prefixed fees must be accepted only in such a manner and on such terms that the medical interest of patients and the dignity and self-respect of the professional and practitioners are not jeopardized”.

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12. ETHICAL ISSUES IN HEALTH MANAGEMENT OF ELDERLY PERSONS

H.I BELL-GAM

INTRODUCTION
In developed countries, an elderly individual is a person aged 65 years or older. The United Nations cut off is 60+ years. In Africa, 60 years and above is the age used for elderly persons, senior citizens or geriatrics. Sometimes age is not the basis of classifying persons as elderly person (EPs) or geriatrics, as some persons below age 60 years with multiplicity of physical and mental disabilities and dependency could be classified as geriatrics.

WHO SHOULD CARE FOR THE ELDERLY?
Nigeria is still far from establishing a national policy on care of the elderly or geriatrics medicine. On average the cost of care of an elderly person is about 2-3 times the cost of care of an adult patient of less than 60 years. The average cost of admitting an elderly person usually is about 30% more than that for a younger adult. Minimum cost of care of an elderly person based at home (on his/her own) is about 30,000 naira per month. In USA and Canada about 95% of the elderly live at home while only about 5% are cared for in institutions. In the UK 96% of the elderly live in the community and 4% in institutions. The objective of care for elderly is to prevent disability and dependency by rehabilitation and support from caring relatives.

The medical care providers in managing elderly persons (EPs), invariably find themselves in ethical dilemmas and challenges in service provisions. Some of the reasons include:
- Economic challenges as EPs more commonly have financial difficulties.
- Abandonment more likely as EPs and Destitute patients (DPs) are more likely to suffer neglect and abandonment.
- Overcrowding of wards may occur as the number of clients needing admission maybe more than provided bed-spaces.
• Under-Staffing is anticipated as currently there are not many trained personnel in this field of Medicine.
• Under-funding is a problem as there is no specific funding for this highly demanding arm of medical services through the department of Internal Medicine.
• Inadequate Infrastructural facilities can hamper adequate and appropriate service provision and impair quicker discharge and more avoidable morbidities and fatalities.
• Service providers’ personal bias in caring for EPs.

All these can lead to medical litigation as EPs and their relatives are becoming more aware of their rights and can petition against or challenge any decision perceived to affect patients negatively as a result of inadequate or inappropriate services rendered or denied to them.

PERSONAL HEALTH INSURANCE, NATIONAL HEALTH INSURANCE SCHEME (NHIS) AND ELDERLY PERSONS.
The uptake of health insurance for EPs remains inadequate in Nigeria. Common misconceptions include
• taking up life insurance implies that one is expecting, wishing or accepting early death
• one is attracting attention to possible financial benefit to your family on your demise

As a result medical costs are borne as out of pocket expenditure by EPs themselves or their sponsors.

The National Health Insurance Scheme (NHIS), which became effective in June 2005, sets out the Standard treatment guidelines and Referral Protocol for Primary Health Care Providers. This produced disease management guideline and treatment protocol aimed at minimizing irrational drug use and the possibility of abuse. It was promoted as “a critical step to promote access to affordable healthcare to all Nigerians”. Although it specified “Pneumonia in adults >60years/with underlying medical conditions, and stated that it “aims to moderate and discourage indiscriminate use of multiple
drugs (Polypharmacy)”, majority of EPs are unfortunately excluded as it is mainly a guideline for the operation of the formal sector social health insurance programme in which the health care of employees in the Formal Sector is paid for from funds created by pooling the contributions of employees and employers. The healthcare services providers are therefore left with no choice than to deny or refuse intake of EPs under this scheme. The NHIS needs to be reviewed to include in its category of beneficiaries all those 60 years and above.

HEALTH SCREENING (HS) FOR THE ELDERLY.
Although most diseases can affect people of any age, some occur almost exclusively within a particular age range and many are most common at a particular stage in life using Shakespeare’s idea of the seven ages of man:
1. The new-born
2. The Toddler
3. The Child to Puberty
4. The Adolescent
5. The Young Adult
6. Middle age
7. Old age.

Health Screening (HS) is important for EPs. This could be initiated by the patient or the doctor. Elective screening occurs when the doctor or public medical authority takes the initiative in investigating the possibility of illness or disability in persons who have not complained of symptoms or signs. For example, government policy may be to encourage EPs to have a health examination on their birthday.

In conducting health screening, one must bear in mind the stages of life and the knowledge of physiological differences and physiological variations among EPs. The use of Reference Ranges (RR) which takes into consideration “95% of the test results obtained from an apparently healthy and usually an age and sex-defined population” become crucial in screening EPs. There are
different RRs for certain analytes in adults and EPs e.g. serum calcium, cholesterol, creatinine, urea and uric acid. Opportunistic screening (OS) for prostrate, breast and uterine cancers in addition to the blood tests listed above maybe a way forward for EPs screening in Nigeria.

Ethical issues inevitably emanate from attempting to conform to good medical practice or allowing the considerations of cost deter the service provider from offering appropriate screening for EPs. Medico-legal issues may become more rampant in the future as EPs could argue that their ailments could have been detected and managed earlier with better outcome should these have been picked up earlier through a local or National HS policy.

**MAKING OF WILLS**

A will is a means to ensure that your wishes, thoughts, desires and instructions are carried out after your death. It is a document that “sort things out in advance”. It is an instruction document that sets out the assets and liabilities of a person at the time the will is prepared. A will, whether verbal (unwritten will), or written was previously viewed as “deathbed statements” made in confidence to the priest. Married couples should not gloss over issues paramount to the well-being of the family at large especially after the death of a spouse. Men should be loving and bold enough to fulfil the biblical injunction that a good man leaves an inheritance for his children. In the event of death, the spouse should legally be designated as the next of kin. The widow particularly, should have her husband’s will in her and that of the children’s favour, and should have joint ownership of properties with legal evidence.

The medical practitioner may be a called as a witness or to give evidence concerning the will of an EP. A witness is usually “a person who gives evidence in a court of law”. Evidence is defined as “all the means, exclusive of mere argument, which tend to prove or disprove any matter of fact, the truth of which is submitted to the judicial investigation. The medical practitioner may find himself
acting as witness to the will or getting the “Power of Attorney” (POA) to execute the will.

**Advanced Health Care Directives and Living Will.**
The society respects that individuals have the ability to make decisions affecting their personal affairs. This presumption enables individuals to refuse any procedure, treatment or medical advice including getting discharged against medical advice. A patient can therefore give instructions regarding what actions should be taken for their health in the event that he or she is no longer in a position to make such decisions as a result of illness or incapacity. This is known as advance directives (AD). Advanced directives can be given as a living will (LW), which is when a patient specifies what should be done or should not be done in the event that he or she loses decisional capacity, or as a Power of Attorney (POA); when a person gives authorization to another person known as a healthcare proxy to make those decisions on his or her behalf should he be incapacitated to do so. The attending healthcare practitioner is usually bound by ADs, as far as it can be ascertained to be genuine. ADs are a rarity in our society, except in some cases of Jehovah Witness members, who having obtained this (especially in cases of need for blood transfusion) wear bracelets indicating this decision. ADs, LWs and POAs, if encouraged amongst our EPs will go a long way in reducing some of the ethical dilemmas that face their healthcare providers.

The Infirm are persons who are severely physically disabled or disadvantaged and unable to care for themselves and or who have been assessed and classified as not having adequate mental capacity to make decisions for themselves. These are persons whom should they have medical insurances, ADs, LWs and POAs in place, would make their medical care a lot easier. Unfortunately these are rarity amongst EPs in developing countries as a result of a combination of issues such as cultural beliefs and myths, lack of adequate education, religious beliefs, conflicts and dilemmas, personal carelessness and fear. The care of such persons inevitably falls on their families and the state. Sadly quite a few will end up destitute and beggars while
others may be institutionalized and some suffer earlier deaths from lack of care. It is also common knowledge that the fear of such individuals with mental or severe physical disabilities or infirmity is real in our societies especially in the rural communities. This fear of getting stigmatized and scorned by others commonly leads to such persons or EPs being hidden away and ignored.

**CARING FOR ELDERLY PERSONS**

From our birth to about the age of 10, we are dependent on others. From 10 to 20, 90% of us are schooling and studying. From about 20-30, we are just beginning to get experience in a job. From 30-40, we begin to have some wisdom, experience and skills. We may also have managed to accumulate some money and capital. Actually the prime of a person's life begins after 40! A study of some four hundred names of the most notable people of all times from all line of activities was done. It was discovered that…

- The decade during which the people were between the ages of 60 to 70 contained 35% of the world's greatest achievements.
- Between the ages of 70 and 80, 23% of the achievements.
- And in the years after their 80th Birthday, 8% of achievements.

*In other words, 66% of the greatest achievements the world has ever known were achieved by persons who had passed their 60th year!*

Here are some practical examples from the past and present:

- Charles Goodyear – the inventor of today's car tyres, invented the process of vulcanisation in his sixties.
- Harland Sanders started the Kentucky Fried Chicken franchise at age of 66.
- Coco Channel started her fashion company at the age of 85.
- Picasso was still painting his masterpiece in his 80's.
- Abraham Lincoln became the President of the United States of America when he was past middle age.
- Nelson Mandela became South African President in his old age.
- Ghandi became an icon in his old age.
- In 2014 National Conference in Nigeria, the average age of the delegates at the conference was reported at 61 years.
The same class of people often described as elders and respected senior citizens have virtually ruled Nigeria for the past 50 years. They’ve occupied the highest-ranking offices in the nation.

Family caregivers (CGs), irrespective of their ages, play a key role in delaying and possibly preventing institutionalization of chronically ill elderly patients. About 80% of help in the home (physical, emotional, social, economic) is provided by family caregivers. When the patient is mildly or moderately impaired, a spouse or adult children often provides care, but when the patient is severely disabled, a spouse (usually a wife) is more likely to be the caregiver.

The amount and type of care provided by family members depend on economic resources, family structure, quality of relationships, and other demands on the family members' time and energy. Family care-giving ranges from minimal assistance (e.g. periodically checking in) to elaborate full-time care. On average, family care giving consumes about 4 hours a day.

Although society tends to view family members as having a responsibility to care for one another, the limits of filial and spousal obligations vary among cultures, families, and individual family members. The willingness of family members to provide care may be bolstered by supportive services (e.g., technical assistance in learning new skills, counselling services, family mental health services) and supplemental services (e.g., personal care [assistance with grooming, feeding, and dressing], home health care, adult day care, meals programs). Supplemental services may be provided on a regular schedule or as respite care for a few hours or days. Care-givers can often obtain reassurance or learn helpful information or strategies for care giving from physicians, nurses, social workers, or case managers. Care-givers can also take the following measures to prepare themselves for care giving and to avoid caregiver burnout or from suffering abuse themselves:

- A care –giver should be treated with dignity and respect.
- Attending to their own physical, emotional, recreational, spiritual, and financial needs
• When appropriate, asking for help with care giving or support from other family members and friends
• Investigating outside groups that can offer psychological support (e.g., support groups) or help with care giving (e.g., counselling, home health care, adult day care, meals programs, respite care)
• If their loved one is hostile or difficult, not taking it personally

Changes in demographics and social values have reduced the number of family members available to care for impaired elderly relatives because of the following:
• Increased life span: As a result, the population of the very old has been increasing. Thus, their children, who are potential caregivers, are likely to be old also.
• The number of dependent and very sick elderly people is increasing.
• Delayed procreation: Combined with increased longevity, this delay has created a sandwich generation of caregivers who care simultaneously for their children and their parents.
• An increasing number of women in the workforce: Previously, women may have provided care for elderly parents, but the demands of a job may diminish or eliminate their ability to do so.
• Increasing mobility of society and the increased divorce rate: As a result, families are more likely to be geographically separated, and family ties are more complex. Nonetheless, in the USA, it was noted that 80% of people ≥ 65 live within 20 minutes of one child.

Care-giving may also become a financial burden. Couples in which one partner cares for the other tend to be disproportionately poor. Care-givers can often obtain reassurance or learn helpful information or strategies for care giving from physicians, nurses, social workers, or case managers.

**ABUSE OF ELDERLY PERSONS**
Definition of abuse demands consideration of a number of different components: relevant age, the setting of the abuse, the abuser, the abused person, the type of abuse and the dimension of the abuse.
Elder abuse (EA) also called "elder mistreatment," "senior abuse," "abuse in later life," "abuse of older adults," "abuse of older women," and "abuse of older men" is "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person." This definition has been adopted by the World Health Organization (WHO) from a definition put forward by Action on Elder Abuse in the UK. Laws protecting the elderly from abuse are similar to, and related to, laws protecting dependent adults from abuse.

The core element to the harm of elder abuse is the "expectation of trust" of the older person toward their abuser. Thus, it includes harms by people the older person knows or with whom they have a relationship, such as a spouse, partner or family member, a friend or neighbor, or people that the older person relies on for services. Many forms of elder abuse are recognized as types of domestic violence or family violence. EA is a relatively new field that raises many complex ethical, legal, and clinical questions. EA which is a form of social problem can have lots of medico-legal implications. It has challenged our understanding of such fundamental concepts as personal freedom, the role of culture in defining family responsibility, and society's obligations to its members.

While there are a variety of circumstances that count as elder EA, it does not include general criminal activity against older persons, such as home break-ins, "muggings" in the street or "distraction burglary", where a stranger distracts an older person at the doorstep while another person enters the property to steal.
INTRODUCTION
Death is a necessary end of all mortals. Medical practitioners invariably, have to grapple with death and dying owing to the nature of their profession. It follows therefore that medical practitioners should develop the right attitudes towards the dying. The job of the practitioner is the preservation of and prolongation of life. However, when this becomes patently impossible, the health team must do what is possible and practicable to make the dying patient come to terms with the inevitable. The fear of death is universal and the terminally ill patient and relations deserve compassion from health care providers.

Death is usually defined as the permanent and irreversible cessation of life. Until about 3 decades ago, the cessation of breathing and heartbeat were regarded as death. However, with modern technological tools, including life support facilities, the patient could be kept 'alive' indefinitely albeit in a 'vegetative state. In 1967 the world's first heart transplant took place in South Africa. This brought out an ethical challenge to the definition of death.

Thus the term "Brain death" as opposed to cardio-respiratory death came to the fore. Before death can be ascertained in an individual, the following must be present:
1. Cessation of respiratory and circulatory functions.
2. Cessation of the functions of the brain including the brain stem.

DIAGNOSIS OF DEATH
Clinical
- No pulse
- No heart beat
- Flat line on ECG
- No respiration
• No reaction to stimuli
• No brain stein functions
• Fixed dilated pupils
• Fixed *dolls* eye movement
• Caloric tests do not elicit nystagmus or any eye movement
• No cornea reflex.

**Brain Stem Death Certification**
For the purpose of organ donation; most ethical committees or institutional review boards would require brain death certification by two registered medical doctors who are independent of the transplant team. One of them must be a medical doctor who is more than five years post registration.

**Preconditions for Brain Stem Death Certification**
1. For an organ to be harvested from a victim/donor there must be an untreatable structural damage to the brain.
2. The victim should have irreversible metabolic derangement.
3. There must be absence of hypothermia in the victim/donor.
4. There must be absence of cardiovascular shock and absence of drug, intoxication or overdose.

**CRITERIA FOR BRAIN STEM CERTIFICATION**
1. Absent Brain Stem Function
   • Pupils fixed and dilated (exclude the present of drug overdose)
   • Absent cornea reflex
   • Absent gag reflex
   • No vestibulo-occular reflex (caloric test)
   • No occulo-cephalic reflex (fixed dolls eye movements)
   • Apnea despite high Pco2. Po2 less than 40 mmHg, Pco2 greater than 50mm Hg when the ventilator is discontinued for 3-5 minutes
2. Absent Cerebral Function

There should be no behavioral or reflex response to stimuli of any kind.
**NB:** The presence of Tendon and Spinal reflexes do not invalidate the diagnosis of brain death. EEG is not useful in evaluating brain stem function

**CARE OF THE DYING PATIENT**

The medical practitioner is ethically bound to continue caring for the terminally ill. The patient must not be abandoned because of the "hopelessness' of the situation. All available specific and technical resources should be brought to bear in order to prolong life as much as possible.

However, in the process, there must be due regard for the dignity of the dying patient. The wish of the patient to die in peace and dignity should be respected; especially when it becomes obvious that the patient will die within six months. Some patients leave a set of written instructions or do-not resuscitate orders (DNR) to ensure that no heroic, dehumanizing, resuscitative measures are put in place when they suddenly fall unconscious. Such instructions should be respected.

**EUTHANASIA**

Euthanasia or mercy killing, done in order to end the suffering of the patient, is not allowed in Nigeria. The Medical and Dental Council of Nigeria and the laws of the federation of Nigeria do not permit Euthanasia either voluntarily or involuntarily.

**Below is the Medical and Dental Council position on euthanasia:**

A practitioner shall be adjudged to be in breach of the ethical code of practice if found to have encouraged or participated in any of the following acts:

a. Termination of a patient's life by the administration of drugs even at the patient's explicit request.

b. Prescribing or supplying drugs with the explicit intention of enabling the patient to end his or her life.

c. Termination of a patient's life through the administration of drugs with or without the patient's explicit request thinking same to be in the interest of the patient.

*MDCN Code of ethics 2004 68, pgs 70-71.*
LIVING WILL
A living will is a set of written instructions or directives specifying a patient's terminal wishes regarding treatment. It may contain directives of what a practitioner should or should not do in the event of coma, brain death or other incapacitation.

It could state the patient's objection to cardiopulmonary resuscitations, artificial nutrition or blood transfusions. The Living Will may also convey the willingness or otherwise of a patient to donate an organ for transplantation purposes. The idea of a Living Will is not yet widely prevalent in Nigeria. However, medical practitioners are enjoined to look out for them and consult appropriate next of kin and legal representatives of the patient in carrying out instructions on Living Wills in order to avoid ethical and or legal conundrums.

DEATH AND GRIEF
Terminal illness and death are naturally associated with grief. The patient and relations usually would be devastated at the prospect of a terminal illness. The medical practitioner should be appropriately prepared and skillful in breaking bad news. It is also important for the practitioner to understand the mental state of the patient or relations when they receive the news. This is in order for the practitioner to act appropriately and ethically in the continued management of the patient. And in the event of death, relate appropriately to the bereaved relations.

Dr. E. Kubler Ross an authority in the study of death and dying, has described the coping mechanisms of the terminally ill. Such patients experience what is now referred to as the five stages of grief. These five stages of grief also apply to the bereaved and persons who have experienced a devastating life event.
The stages are as follows:

**Stage 1: Denial:**
The first stage of grieving usually consists of the feelings of denial. The patients or relations just refuse to believe the obvious or inevitable. They usually would suggest that the doctor or health care provider has made a mistake; that they should seek a second opinion, look at the results again etc.

In Nigeria, the phrase "it is not my portion" readily comes to mind.

**Stage 2: Anger:**
As reality dawns, the grieving person can become very angry. The anger may be at self, God or the medical practitioners. Doctors and nurses have been known to be beaten up at this stage.

**Stage 3: Bargaining:**
Persons in grief may respond with bargaining; for example they may attempt to bargain with the doctor, and other health personnel to convince them that the doctor is wrong. They may bargain even with God, just to spare them and prevent the inevitable. The feeling of guilt may be superimposed and the bereaved person tends to feel that he or she may have been responsible for the calamity either through acts of omission or commission.

**Stage 4: Depression:**
This is a very dangerous state of grief. When depression sets in, all manner of behavioral traits may be exhibited. The patient or bereaved may cry a lot, become moody and react inappropriately to situations and events. Suicide bids have been known to occur at this stage and medical practitioners should be wary and anticipate this.

**Stage 5: Acceptance:**
Finally, the bereaved or terminally ill patient may reach the stage of acceptance. This is when he or she comes to terms with the illness or bereavement. At this stage the patient may decide to write or revise his or her Will and they may even plan their funerals. Bereaved relations especially spouses may decide to keep away clothing items, photographs etc that may bring back their anger, depression or even frustration and move on with their lives.
Medical practitioners would need to realize that these stages may not all be present in all grieving persons and some may be prolonged in others. Practitioners need to be well equipped to deal appropriately with these scenarios.
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APPENDIX

MDCN Approved proforma for obtaining consent for anesthesia, surgical operations and clinical procedures

Hospital Clinic…………………………………………………………

Address:………………………………………………………………

CONSENT FOR SURGERY/ PROCEDURES

I………………………………………………………………………………

of……………………………………………………………………

(full names, surname first) (full address not P.O. Box)

Hereby, after detailed explanation of the advantages and disadvantages to me by

Dr……………………………………………………………………… willingly

consent to the full names, surname first)

Procedure of…………………………………………………… on

(Specify)

Myself/child/spouse/mother/father/others…………………………

…………………………………………………………………………

(indicate as applicable)

I affirm that I clearly understand the language of presentation. The option to think over the procedure for a period before assenting was also presented to me.
I further affirm.

A. That the extent of the procedure and mode of anesthesia are left to the discretion of the physician.

B. That any additional surgery or procedure to that described above will only be carried out if necessary and in my best interest and can be justified for medical reasons.

Signature:............................................

Or Thumb Print:..........................

Full Names:.................................

(Patient or Guardian)

Address:........................................

Date:............................................

(Witness)

Date:............................................
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