Regulating the medical profession in Nigeria: The medical and dental practitioners council in perspective

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Abstract

The medical personnel are bound by the provisions of law guiding the operations and practice of the Medical profession in Nigeria to ensure strict adherence to the medical code of conduct. Using the legal approach, this paper interrogates the institutional mechanism for enforcing these regulations by studying the Medical and Dental Practitioner Council of Nigeria's activities. It also explores the Medical Doctor's patient's relationship to ascertain the extent to which the regulatory body has sanctioned erring doctors who violated the code of conduct/ethics of the medical profession in Nigeria. The article argues that the absence of a regulatory framework breeds indiscipline. It concludes that the Medical and Dental Practitioner Council of Nigeria should rise to their responsibility to restore confidence in a would-be patient that may likely seek medical advice or solution to their problems.

Introduction

It is inconvincible that a patient in the general framework of a hospital health care may receive health care from doctors and other health caregivers such as nurses, pharmacists, physiotherapists, social health workers, medical laboratory scientists, record technicians and many others. The organisation and regulations on these professions are found in various legislation and professional ethics rules regulating them.[1]. However, this paper focuses primarily on the institutional framework for doctors. This is because the doctor's hospital

[1]See, for example, Nursing and Midwifery (Registration) Act, 1779, Cap N143, LFN 22004, WHICH ESTABLISHES THE Nursing and Midwifery Council of Nigeria for the registration, discipline OF MEMBERS. See also Pharmacists Council of Nigeria Act, 1992, Cap P17, LFN, 2004.

management position is paramount, and its basic principles can analogically apply in a broad context to the other professions.[2].

The Medical and Dental Practitioners Act (MDPA) 1988 do not use the phrase 'doctor'. Instead, it uses the term 'medical practitioner' and 'dental surgeon' to describe its registered members. Accordingly, our focus here would treat both under the generic description of a doctor because of its wide conventional orthodox usage. Section 8, however, provides that a person shall be entitled to be fully registered as a doctor if (a) if he/she possesses a qualification approved by the Medical & Dental Council and (b) if he/she holds a certificate of experience issued pursuant to Section 1l of the Act. This certificate is issued to the doctor after the compulsory housemanship of one year or such other time as may be prescribed or specified. The Council will only recognise a qualification given by an institution whose training course is designed for persons seeking to become doctors if the institution is appropriately established and equipped for the training as was stated in the Act.[3].In pursuance of its statutory function of determining the standard of medical knowledge and skill[4], the Council may permit provisional registration of medical graduates to practice as doctors on what is often referred to as housemen on a compulsory apprenticeship in a recognised medical centre.[5]

With the recent enactment of the National Health Insurance Scheme (NHIS) Act, a doctor may be engaged in the practice either as a general practitioner or hospital doctor whose duties is to manage the health care of any patient who approaches the hospital for the treatment within the NHIS scheme or outside the Scheme as a private practitioner.[6]

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[2]Note that in Nigeria, the medical and dental professions are regulated under a common umbrella, see Medical and Dental Practitioners (MDP) Act, 1988, Cap, LFN 2004; See also Code of Medical Ethics in Nigeria for Medical and Dental Practitioners, revised edition of January 2004, Published by Medical & Dental Council of Nigeria.

[3]S.9 Medical and Dental Practitioners (MDP) Act, 1988, Cap, LFN 2004.

[4]S.1(2)(a) Medical and Dental Practitioners (MDP) Act, 1988, Cap, LFN 2004.Medical and Dental Practitioners (MDP) Act, 1988, Cap, LFN 2004.

[5]S.12 Medical and Dental Practitioners (MDP) Act, 1988, Cap, LFN 2004.

[6]See National Health Insurance Scheme (NHIS) Act, 1999.

Conceptual Underpinnings

In the provision of Section 1 of the Act, a beneficiary under the Scheme described as an insured person is entitled with his dependants to the benefit under the scheme-good quality and cost-effective health care services.[7]A registered beneficiary under the Scheme is expected to enjoy easy access to a wide range of health care that includes a diagnostic test, family planning, hospital care, dental care, even prescribed drugs and many more. Also, Section 18 provides that the services to be enjoyed from the providers are defined curative care; prescribed drugs and diagnostic tests; maternity care for up to four live births; preventive care, including immunisation, family planning, ante-natal and post-natal care; consultation with a defined range of specialists; hospital care in a public or private hospital in a standard ward during a stated period for physical and mental disorders; eye examination and care, excluding tests and the provision of spectacles; and a range of prosthesis and dental care as defined. Subsection 3, 'defined curative care' is construed to mean as defined by the Council, i.e. the Governing Council of the National Health Insurance Scheme (NHIS) means is that the type of curative care a beneficiary can receive may well be restrictive or expansive depending on what range the Council decides.

Furthermore, a similar caveat is placed on consultation with specialists and care related to a prosthesis and dental care. Even where the care required is maternal, the beneficiary can only enjoy it to a maximum of four children. Hospitalisation in a public or private hospital during physical or mental illness is similarly restrictive. Here, the patients need not be cured or get a solution to their health challenges; i.e., it is not made to depend on a cure. It depends on a stated period, presumable to be determined by the Council. These restrictions are to some extent at variance with the proclaimed objectives of the Scheme outlined in the preamble and Section 5.

The Act establishes a scheme known as the National Health Insurance Scheme [NHIS] to provide health insurance that will

[7]See also s.5, which appears a similar objective but goes further to include the following as policy objective, limit the rising cost of health care services, ensure equitable distribution of health care cost; improve and harness private participation in health caregivers.

entitle insured persons and their dependants(loosely referred to as beneficiaries) to good quality and cost-effective care.[8]Under section 16 of this Act, an employer with a minimum of ten employees may enter into the Scheme by paying contributions deducted from its employees' wages. Once that is done, all persons from whom deductions are taken together with their registered dependents become beneficiaries Deductions so made by the employer are to be remitted to a designated Health Management Organisation (HMO) manner directed by the Council.[9]The Act also allows a person not liable to contribute (presumable because his employer chooses not to register under Section 16 or is not within traditional employment structure) to apply for registration as a voluntary contributor under the Scheme.[10] Considering these contributions (capitation payment in respect of the contributor or such approved fees stated by the Council), the Health Care Provider (HCP) comes under an obligation to provide the beneficiary's care.[11]

The structure of the Scheme shows that the Council approves and registers HMOs under the Scheme who shall function as private or public health maintenance insurance organisations if they satisfy the registration requirements of the Council.[12] Upon registration, they shall function to collect a contribution from the contributors, make capitation payment to the HCP, and render returns of its activities to the Scheme.[13] The HMO is only authorised to contract a registered HCP to render health care services under the Act. It is also responsible for ensuring that contributions received are adequately kept as stipulated by the Council. It is further expected to establish a quality assurance system to ensure qualitative health care is given to contributors

[8]sJ of NHIS Note the Scheme is made a body corporate by sJ(2)(a). Responsibility for the management of the Scheme is entrusted to its Governing Council (s.2). The functions of the Scheme are set out in s.6. They include registration of Health Maintenance Organization (HMO) and Health Care providers (HCP) sustaining the Scheme by appropriate regulation as the proper regulatory body charged with its management. etc.

[9]s.17 (1) NHIS Act, 1999.

[10]s.17 (3) NHIS Act, 1999.

[11] See s.18 NHIS Act, 1999 for a detail of the health care services.

[12]s.19 NHIS Act, 1999.

[13]s.20 NHIS Act, 1999.

by HCPs in carrying out its functions under the Scheme. The Scheme provides a list of accredited health care providers/hospitals (HCPs) from which a beneficiary can choose to register. In the event of sickness, the beneficiary will receive treatment at his HCP facility by presenting his identity card. HMOs act as financiers of the Scheme. Essentially they are insurance companies set up to facilitate the provision of medical services to contributors/beneficiaries.

On the other hand, an HCP may be a licensed government or private hospital or health caregiver. More importantly, a doctor who wishes to be on the Scheme's list may apply for listing with it. Once listed, the relationship between the General Practitioner (GP) and the Scheme may take on one or all of the following characteristics- (a) contractual- creates a contractual relationship between the GP and the Council for providing medical services. It has been suggested that is the proper relationship created under the arrangement because the GP, from the nature of services he renders, can hardly be construed as an employee of the Scheme, (b) the relationship may also take on a statutory flavour within the realm of public law. What that means in effect is that the parties' duties and rights get construed in the context of the NHIS Act (c) the relationship may take on a hybrid character, not wholly contractual or statutory, but something in between both.

Meaning of medical doctors/patients relationship are defined in *Roy v. Kensington & Chelsea Family Practitioner Committee*[14] the court in England was faced with defining the boundaries of medical services provided under the English National Health Service Act 1977. Dr Roy brought an action in debt against the defendant Family Practitioners Committee for work done. He based the debt claim on a breach of contract. The Committee reduced his practice allowance by 20 per cent on the ground that he was devoting less than satisfactory time to his practice as a GP engaged under the NHS. It was not disputed that he had been absent from his practice by reason of family, sickness and holiday. Still, it was conceded that there was no complaint from patients against him about the time devoted to his practice in the context of adequate care to them. They received treatment from

[14](1990) 1 Med LR 328, on appeal to House of Lords (1992) 1 AC 624

the locum employed by him as his practice manager. Roy contended that his relationship with the Committee is contractual, to provide general medical services to NHS patients. By employing a locum in his absence, he had perfected the obligation. Meanwhile, the Committee had reduced his practice allowance by 20 per cent, so he contended that the reduction was a breach of contract. He accordingly claimed a refund of the money deducted. They sought to have the claim struck out as an abuse of process on the basis that the relationship between theparties was a matter only of public law. White, J stated that though there were contractual echoes in the relationship between the doctor and the Committee, those were deceptive and that the claim is an abuse of process. It was accordingly struck out.[15]The parties' rights and duties were dependent on statute, and the duty which the Committee discharged was a public law function. That being so, the court would not substitute its judgment for that of the Committee. The plaintiff can only vindicate his claim for deduction by way of an action for judicial review.

The English Court of Appeal held the lower court wrong, stating that the parties' relationship was contractual. According to Balcombe L.J (Nourse and Neill LJJ agreeing), the application by the GP to the Committee, as the NHS employer in the locality and its acceptance by it, constitute a contract. Curiously, in reaching the decision, the Court of Appeal did not refer to an earlier judgment of the Employment Appeal Tribunal in *Wadiv. Cornwall & Isles of Selly FPC*'[16]to the effect that the relationship is one of contract. Accordingly, the House of Lords in the *Roy* appeal sought to resolve the conflict.[17] The Law Lords stated that the relationship is governed by statute and that it is erroneous to import into it contract principles. Roy was said to acquire a bundle of rights under the statute, which he could vindicate against the Committee for payment. Of interest, Lord Lowry

[15] See (1989) 1 Med L.R. 19.
[16](1985) ICR 492.
[17] See (1992)1 AC 624, (1992) 1 All ER 705. Note under the English NHS, the Committee merely administers on behalf of the district health authority the Scheme on its behalf. This may be likened to the functions of HMO's under s.20 (g) and the Zonal Health Insurance Offices (ZHO) under s.22(e) established by the Council under the NHIS Act 1999 in Nigeria.

noted that the Committee has no right to withhold payment to the GP under the Scheme from the Secretary of State who administers it. In his Lordship's view, it is a mere conduit pipe for the payment. Therefore, the House of Lords refused to strike out the claim even though, according to Lord Bridge, the relationship was probably not contractual. 'Nevertheless, the terms which govern the obligation of the doctor on the one hand, as to the services he is to provide, and of the family practitioner committee on the other hand, as to the payment which it is required to make to the doctor, are all prescribed in the relevant legislation, and it seems to me that the statutory terms are just as practical as they would be if they were contractual to confer upon the doctor an enforceable right in private law to receive the remuneration to which the terms entitle him.[18] According to Lord Lowry, the court had jurisdiction to entertain the doctor's action because it was concerned with a private right. It was one for an ascertainable sum of money. The existence of any dispute regarding entitlement meant that the doctor was alleging a breach of his private law rights by the Committee's failure to perform their public duty.[19]

This raises certain conceptual and procedural issues. If the relationship is statutory, it should follow that a GP who disputes any aspect of the relationship will either have (a) a specific statutory remedy, say an appeal to the Secretary of State against a particular matter or (b) enjoy the right of judicial review of administrative action. It is suggested that a curious analysis of the Nigerian statute on health insurance show no significant departure from the English. So *Roy* may well summarise the legal position between the GP and Scheme. Section 26 makes explicit that a statutory arbitration board shall be established under the Scheme for the purpose of considering a complaint by any aggrieved person on any matter relating to a violation of any of the provisions of the Act; against any agent of the Scheme or HCP An ordinary reading of the provision, gives the impression that it only covers as it were, complains by contributors. This should be so considering the persons against whom complaints can be sought against the Scheme or HCP agents. But it is suggested that the arbitration jurisdiction is more expansive. The power as

[18](1992) AC 624 at 630.
[19] Ibid, at 654

conferred by section 26(2)(b) extends to all cases relating to a violation of any of the provisions of the Act.[20]

The Act, unlike the English model, does not contain a provision that the GP shall give treatment personally. Under the English model, the GP is required to provide personal care to the patient even though he could use a deputy to provide general medical services so long as he ensures that he takes steps to continue the patient's treatment Before employing a deputy to provide the services, the GP shall take reasonable steps to satisfy himself that the person is competent to discharge the duties for which he is employed That notwithstanding the GP will be held vicariously liable for all acts and omissions of his deputy or anyone acting for the deputy.

The English Act provides that the GP shall only employ a deputy after obtaining the necessary NHS authority's consent. However, where the deputy is also on the NHIS list, he alone would be personally liable for his acts and omissions. The GP is required to make known to his patients such times and places when he would be available. He is also required to keep a record of the patient's illness and treatment. He is prohibited from charging the patient a fee, save in exceptional situations where the Act or regulation made there under permits charging, e.g. where he makes an examination at a place other than the usual hospital, such as at the police station. Even though the Nigerian NHIS Act does not explicitly contain these stipulations, it is reasoned that regulations when made by the Council, in pursuance of the objectives of the Act, would incorporate these acceptable features of the English practice.[21] Under the English model and being on the list, the GP may also apply to be placed on the list of specialists. Generally, a GP may withdraw his services by giving a three-month notice to the Scheme. A doctor's name would be removed from the list if he dies, ceases to be a registered medical practitioner, or is removed by the NHIS for professional

[20]This certainly should cover complain within the bracket of Dr Roy Aforesaid. As an omnibus provision, it covers complaints either way, from and against all relevant parties under the Scheme, beneficiaries, the Scheme and its operatives such as its Council, ZHIO, etc. and HCPs it relates to a violation of the Act.

[21]See s.6(j) of the NHIS Act, which empowers the Scheme to do such things as necessary for achieving the NHIS Act's objectives.

incompetence and the Like, e.g. breach of his terms NHIS employment.[22]

Hospital Doctor

Here, we start by asking a question who is a doctor? And what differentiates 'Doctor' from a Hospital Doctor? The hospital doctor working in an NHIS hospital is not subject to the statutory framework that governs the GP service under the Scheme. His legal relationship remains that of an employee with the NHIS service provider, the HCP, and is governed by a general employment contract between him and his employer.In a generic term, a doctor undertakes and practice to manage the health of any patients at any point in time but not under any employment regulation.[23]

Whether contract or tort principles or both govern the NUIS service rendered to a patient by the GP or hospital doctor is the subject of some controversy. Some scholars are of the view that following the House of Lords decision in *Pfizer Corporation v. Ministry of Health*[24] - which decided that if services are provided pursuant to statutory obligation, the implication of contract would be inconsistent with a statutory regime - gives the impression that NHIS services should be defined only in the bracket of its statutory framework. Flowing from it, the doctor-patient relationship is to be governed exclusively by the NHIS Act. Any other relevant statute and regulations made under the powers conferred by the Act.[25] It, however, must be admitted that such a position does not put an NHIS patient in a less favourable

[22]See Roy's case (1992) 1 AC 624.
[23]For discussion on the statutory intervention in matters of a general contract of employment of doctors in England, see M Siddal, Not As Well As Can be Expected (1992) 142 *New LJ* 763. B. Raymond, Employment Rights of the NHS Hospital Doctor in C Dyer *Doctor, Patients and the Law*(1992) both cited in Kennedy & Grubb, above n.24 at 45 and on the mature of the changed NHS medical services provided in England, see D. Hughes, The Recognition of NHS; The Rhetoric and reality of the Internal Market (1991) *54 MLR 88.*
[24](1965) AC 512
[25]A.P. Bell, The Doctor and the Supply of Goods and Services Act, 1982 4 *LS* 175, see Lord Pearson Committee Report. The Royal Commission on Civil Liability and Compensation for Personal Injury, 1978 Report, Cmnd 7054.

position to a private patient because the same legal and factual considerations determine when a breach of duty in contract or tort or both is raised under the NHIS and common law rules.[26]

The other contrary position is that the relationship can be both contractual and statutory contemporaneously. This is attractive for two reasons: (i) the existence of a statutory duty is not necessarily inconsistent with a contract to provide services.[27] It is plausible to envisage situations where a doctor's statutory duty to provide medical services can be performed within a contract framework for valuable consideration while rendering services within the statutory context. (ii) it is also conceivable for consideration to move from the patient to the doctor on the basis that the doctor would apply for listing with NHIS.

In the provision of services, the English Act incorporates several treatment standards to reflect an individual patient's particular circumstance. For example, different treatment regimens are prescribed for first-time patients, the aged, children and those that have not regularly visited their doctors for a long time. Provisions on standard treatment for these exceptional patients are regulated under the Act. For example, for a first-time patient, the doctor is also rendering usual medical services requested, under obligation within a time frame specified, to invite the patient for consultation. During a consultation, the doctor is required to undertake a physical examination, make a medical record of the patient's history and access what manner and extent personal medical services would be required. Regulations along similar lines by the Council under the NHIS Act in Nigeria would be recommended.

Exploring Doctors Patients Relationship

A doctor who renders services creates a doctor-patient relationship once there is a patient's factual request and a corresponding undertaking by him to treat. But in certain exceptional cases, the relationship may come into being without a request. That notwithstanding, in all cases, the relationship will only arise when there is an undertaking by the doctor. A no-request accompanied with an undertaking would usually occur in

[26]See Pearson Report above, n. 22
[27] See *Roy* case (1992) AC 624

emergencies or where the patient is unconscious. These may also arise where a doctor is employed by a third party to treat or examine the patient, e.g. an occupational doctor who examines an employee. When made by the Council in Nigeria under the Act, it is expected that regulations would generally regulate the circumstances of the request, undertaking and termination of the relationship under the NHIS Scheme. Whatever the regulated standard of care should ordinarily follow the traditional *Bolam* principle.[28]

Where a doctor is employed by a third party to treat a patient, in which case there is no request by the patient, the duty of care remains intact, as though the relationship were created by request. However, in the context of no-request, the question that could become controversial is whether the doctor is under a duty to disclose to the third party who employs him.

The ambit of the duty to disclose and the extent is generally circumscribed by the doctor's duty of confidentiality. In *Green v. Walker*[29] confidentiality and breach of duty of care were the issues. G was the employee of an offshore company. As a condition of his employment, he had to undergo a medical examination as to fitness. Dr W, who examined him, issued a report to his employer, stated that he was fit and employable without restriction. Things, however, turned out badly. One year after the report, G was diagnosed with lung cancer. G for himself, and his daughter, sued W claiming damages for negligence because, if he had carried a proper diagnosis, he should have discovered the early stages of cancer, which could have helped him take early preventive actions.

The doctor's failure in this respect was said to reduce his chances of survival and life expectancy. While the suit was pending, G died. W then moved for summary judgment on the grounds that no relationship exists between him and G because G's employer was the person who employed him. The issue before the court centred on whether W had a duty to G, in the character which required him to perform the examination with standard medical

[28]See *Bolam v. Friern Hospital Management Committee* (1957) 2 All ER, 118 (1957) 1 WLR 582. SEE ALSO *THARKE V. Maurice* (1986) 1 All ER 497 and Lord Nathan, *Medical Negligence* (1957)

[29] (1990) 910 F 2d (5th Circ.CA)

care and skill and further, to report his findings to G, even if it constitutes a threat to his health. The court held that the examination by the doctor was sufficient to create a doctor-patient relationship. Accordingly, the doctor was expected to exercise the care and skill expected of a professional doctor of his calling. He was also under a duty to disclose the examinee, G, of any finding which raise danger to his health.

Though the issue has not specifically being decided by the English courts, it is suggested that the English courts would follow the ratio in *Green v. Walker*.[30] The Nigerian position should be no different. That notwithstanding, whether failure to disclosure to the examinee would amount to a breach of duty depends on the nature of the doctor's undertaking. For example, a doctor undertakes examination in circumstances where he covenants to disclose only to the third party who engages his services, say in pursuance to insurance, there ought to be no obligation to disclose to the examinee. But it can be argued that such an undertaking is fundamentally inconsistent with the doctor-patient relationship, laced in trust and confidence.[31] Arguing from that perspective, it would be strong to state that all such undertakings are void for attempting to remove the very essence of medical treatment and examination. This argument is attractive, especially when considered in the context that a patient's request is not a prerequisite to raise the doctor-patient relationship. All that is required is the undertaking of some sort to provide medical services.

The English Unfair Contract Terms Act, 1977 fortifies the argument in Section 2 of the Act, expressly stipulates that a person cannot by reference to any contract exclude his liability for death or personal injury resulting from negligence. Suppose restriction of the doctor's undertaking would not shield him from personal injury and death arising from negligence. In that case, it necessarily should follow that a violation of the disclosure duty to the examinee cannot be excluded by contract with, say, an employer in an occupational treatment from that perspective, it is suggested that a doctor who discloses information to the patient may be adopting a safe course. However, it can be argued

[30](1990) 910 F 2d (5th Circ.CA)

[31]See Kennedy & Grubb, above n. 24 at 75, see *Thomsen v. Davidson* (1975) Qd R 91 at 97.

that the absence of legislation similar to the English Unfair Contract Terms Act in Nigerian is a warrant for excluding the argument of a duty to disclose. If this position is accepted, a Nigerian doctor would have no obligation to disclose if he has expressly agreed to restrict the information to the third party.[32] However, a strong case for disclosure relying on arguments along the *Green* case lines and the English Unfair Contract Terms Act, 1977, as stated above, may dictate disclosure as safe practice for the Nigerian doctor.

Noteworthy is that the doctor-patient relationship may also be raised even where the patient is incompetent, as where he is unconscious or mentally retarded.[33]

Medical and Dental Practitioner Council of Nigeria Malpractice Discipline Procedure

Our focus here will be concerned with means other than court litigation for handling cases of medical malpractice. Therefore, what is focused on is the professional procedure for accountability of the doctor under the professional rules of the Medical and Dental Council (the Council). Generally, there are two ways of ensuring accountability outside recourse to courts for medical malpractice. They are (a) the professional self-regulation method and (b) public procedure for holding doctor's accountable. The Medical and Dental Practitioners [MDP] Act, l988, establishes the Council as the body responsible for; determining and reviewing the standards of knowledge and skill for persons seeking to become members of the profession. Accordingly, it is empowered to establish and maintain a register of members; review and prepare from time to time a statement of code of conduct considered desirable for the practice of the profession and any other functions conferred on it.[34]In pursuance

[32]But cf. *Smith v. Eric* (1989) 2 All ER 514.
[33]See *Re F. mental sterilisation* (1989) 2 All ER 545, (the court half that the relationship may arise without request by the patient and that it could involve services rendered during emergencies). See also Nield J in *Barnett v. Chelsea & Kensington HMC* (1968) All ER 1068.
[34]See s. (2) Medical and Dental Practitioners Act (MDPA) 1988.

of these powers, the Council have made several regulations on professional conduct.[35]

The 2004 Rules was informed by the Council's experience in the course of a preliminary investigation by its Medical and Dental Practitioners Disciplinary Tribunal [Tribunal] and judgments of the Nigerian Court of Appeal Supreme Court on matters of the professional discipline of members. Interestingly, this new Rulehas has been styled code to reflect its intended legal status, making it more solemn and respectable in consonance to document the right legal status. The code is intended to enhance the practice of the profession within the framework of conscience, dignity and its Codal provisions.[36]

The accountability of doctor's to the public is discharged primarily through the procedure for handling complaint from the public against medical doctors. In pursuance of the MDP Act, the Tribunal is established, charged with the responsibility of considering and determining any case referred to it by the Investigating Panel. The IP is charged with the following duties of (a) conducting preliminary investigations into cases where it is alleged that a member in his capacity as a doctor misbehaves or for any other reason is subject to proceedings of the Panel. In carrying out this function it is vested with powers to compel persons by subpoena.[37]Complains are carefully investigated in the vast majority of cases. It may not always result in reference to the Tribunal via the President of the Council. It may end with a letter of advice or admonition to the doctor concerned. Suppose in the course of its investigations it adjudges that a doctor's conduct is prima facie infamous. In that case, it shall prepare appropriate charges and forward them to the Secretary of the Council.[38] The report is what forms the basis on which the

[35]For example, Medical and Dental Practitioners (Disciplinary Tribunal and Assessors)Rule 1966. See also Code of Medical Ethics in Nigeria (Rules of Professional Conduct) issued 1st January 1990, revised 1st January 2004.

[36]See Introduction to the Code of Medical Ethics in Nigeria (Rules of Professional Conduct) issued 1ST January 1990, revised 1st January 2004 at 3.

[37]S. 15 MDPA 1988.

[38]S.3 of Disciplinary Rule

President of the Council will set up the Tribunal.[39] The Tribunal operates like a court. If it finds the doctor guilty, it may make any of the following orders: (a) that the name of the doctor be removed from the register of members, or (b) suspend the doctor from the practice of medicine, or (c) admonish the doctor.[40] In addition to the Council procedures stated above, some well-run hospitals have ethics committees that internally handle patients' complaints within their facilities.[41]

The Medical and Dental Council

Our take in this section would be concerned with an analysis of the Medical and Dental Practitioners Act, 1988 (the Act), the Medical and Dental Practitioners (Disciplinary Tribunal and Assessors) Rules, 1966 (the Rules) and Code of Medical Ethics, 2004. The centrality of the Council is emphasised by the very first provision of the Act. Section 1 provides for the establishment of the Council with the enormous powers and duties of the general superintend of the profession in Nigeria. It is charged with the responsibility of (a) determining the standard of knowledge and skill for persons seeking to become doctors and to review same from time to time (b) ensuring the establishment of and maintenance of a register of members and the publication of members list from time to time (c) reviewing and preparing from time to time a statement code of conduct and (d) any other functions conferred on it by the Act Its composition reflects both streams of the profession, medical and dental practitioners.

As part of its statutory functions, the Council empowered to appoint a Registrar, who shall prepare and maintain on behalf of the Council the names, addresses and qualification of members. In the exercise of this function, he is required to divide the register into three parts, namely; (a) fully registered members (b) provisionally registered members (c) persons granted limited registration under section 13.[42]Section 13 provides that the

[39]S.5 of Disciplinary Rule
[40]S.16 (2) of the Act. For detail reading, see C. Ham *et al* (eds.) *Medical Negligence and Accountability* (1988), ES Akpata, *Medical Ethics,* Lagos: Lagos Univ. Press, 1982.
[41]R.E. Klien, *Complaint Against Doctors* (1973); A Grubb (ed.), *Challenges to Medical (1992)*
[42]S.6 MDPA 1988

Council may grant limited registration to any person employed in an approved hospital or institution in Nigeria in a doctor's capacity if he intends to be in the country for a limited period in the employment in question. The Council may also grant such limited registration if a person has passed the assessment examination, of the Council, following some qualification obtained outside Nigeria that is acceptable to the Council. A curious reading of the word "and' between subsection (a) and (b) would seem to give the impression that the general tenor of section 13 applies to doctors who are trained outside the country, who subsequently take up employment in Nigeria.

The mere fact of a foreign doctor's employment in an approved hospital is not sufficient. The Council must further be satisfied that he possesses a request medical qualification for medical practice. Besides, the applicant for limited registration may be required to pass any assessment examination by the Council required of him. Whether such an examination is needed is at the discretion of the Council. Subsection (2) states explicitly that limited registration shall terminate at the time permitted by Council or such time as the doctor's employment ceases. Whether the employment of such a doctor when terminated by his employer should automatically be the basis of the withdrawal of his limited registration is a matter solely to be determined by the Council. Its decision is made conclusive by subsection (6). A limited registered doctor is not permitted to open or manage his private hospital. This means that although he can manage a public hospital if that constitutes part of his terms of employment, he cannot establish and operate a private clinic of his own.[43]He is, however, liable for all his acts and omissions under his employment as a doctor, even though the Act states that he would not be accorded the status of a fully registered doctor in all other matters under it. Accordingly, he cannot enjoy, for example, the privilege of being a Council member. The Registrar's duty includes making a necessary alteration to the register, removing the name of a registered member who has died or becomes insane.

A person who holds a qualification approved by the Council and has a certificate of experience issued in pursuance of section II

[43]S.6 MDPA 1988

shall be eligible for full registration.[44] As a general rule, the Council recognises a university degree in medicine or dentistry from a recognised institution.[45] Section II makes it mandatory for the doctor to obtain a certificate of competence from a recognised institution. The mandatory training leading to the certificate is usually referred to as *housemanship*. The time period is usually one year, although it may be longer or shorter than one year, because the Council may by regulation specify the length. Before full registration, a person who has obtained a recognised medical or dental certificate from a university may be granted provisional registration pending the mandatory training on competence under section II.

Section 17 makes it an offence for any person who is not a doctor to hold himself out as one. Under section 19, the Council is vested with the power to make regulations, rules, or such orders incidental and supplementary to the Act. In pursuance, of this power, the Council made the Rules.[46]

The First Schedule to the Act is a supplementary provision relating to the Council. It makes provision for matters such as qualification and tenure of members and proceedings of the Council. The Second Schedule is the supplementary provision relating to the Disciplinary Tribunal and Investigating Panel. The Attorney General under the Schedule is responsible for making rules as to the selection of members of the Tribunal and procedure to be followed in receiving evidence. For purposes of advising the Tribunal on the question of law, the Council shall, on the nomination of the Chief Justice of Nigeria, appoint an assessor to the Tribunal.

The Rules govern the procedure for trial.[47] The Tribunal has similar powers as a court of law. Its proceedings shall be in public. It has the power to adjoin cases, order payment of costs, pronounce on guilt, refer to the Attorney General for necessary

[44]S.13 (5)(MDPA) 1988
[45]S.8 MDPA 1988
[46]S.9 MDPA 1988
[47]The Rule is made pursuant to the Council's power under the repealed MDPA 1963. The Rules continue to apply despite the repeal of the 1963 Act to all matters of discipline and assessment but with necessary modification in the context of the 1988 Act and the 2004 Code of Ethics.

action any person who makes a false statement before it and extend the time to do anything under the Rule.

The code, as previously stated, replaces the 1980 Rule on ethics. Unlike the previous 48 sections of the old Rule, the Code has 70 sections. It is divided into eight parts. Part A deals with preliminary matter& it contains the preamble and general matters. Part B deals with professional conduct. Part C discusses the question of malpractice. Next is a section on an improper relationship with colleagues and patients. It is followed by a part dealing on aspects of private practice. Part F deals with self-advertisement and related offences. The G part deals with a conviction for criminal offences. The final part is styled miscellaneous.

Provisions of the Medical and Dental Practitioner Council Act

Part A of the Act

The Act begins with a preamble and set out the objective of the code: namely, to preserve the primacy of the profession and its acclaimed esteem.

Immediately after the preamble is rule 2 on the induction of new members. It is an innovation not contained in the old Rule. It fills a lacuna under the 1988 Rule. By this stipulation, the Registrar of the Council is enjoined to administer on new members at an induction ceremony the Physician Oath. The solemn occasion can, in a far-reaching manner, leave a lasting ethical impression on new members that can significantly improve standards. Rules 3 and 4, however, specifically demand member's allegiance to the profession and respect for colleagues. As supplementing and amplifying the three classes of registered members under section 6 (3) of the Act, it includes a fourth category, the registration of specialists.[48] Section 6 (b) prohibits a member from practising for any year if he defaults to pay practice fees. This is a superfluous stipulation because Section 14 of the Act already so stipulates. Rule 7 is an improvement on the 1988 Rule in that it provides a comprehensive guideline for non-indigenous doctors. It

[48]Rule 3-6 provide for reference of prima facia case to the Tribunal.

recognises the value of exchange programme for doctors recognition of their value, rule 7 (d) states that should an exchange programme doctor wish to remain to practice after the expiration of his programme, the Council will assess him further for retention as a limited registered member or request him to sit for a proficiency examination.

Rule 8 is in *parimateria* with rule 5 of the 1988 Rule. It incorporates by reference to the Venice Declaration of 1983 of the International Code of Medical Ethics. Rule 9 restates general ethical principles, such as that which requires the doctor to promote the health of his patient, uphold the dignity of the profession etc.[49] Rule l0 is in *parimateria* with rule 7 of the old Rule. It lists the rights and responsibility of members.[50] It states that only persons who have undergone the course of training designed to make them doctors in an approved institution by the Council can be licensed to practice. As an improvement on the old Rule (the 1988 Rule does not make a specific provision on this matter), section 11 deals with clinical etiquette. It states, for example, that treatment procedures should respect the appropriate privacy of the patient and be empathetic. The doctor must avoid smoking in the clinic and ought to guard against acts or omissions that could provoke allegations of impropriety. Rule 12 is a classification of the hospital. Noteworthy of mention, it discourages the establishment of hospitals as strict business enterprises or as limited liability companies under relevant laws. The rationale for this must be the fact that the ethics of the profession requires an injection of qualities such as empathy, maintenance of honour, fidelity, trust and the likes, which may be difficult to incorporate into the main purpose of the agency philosophy maximising owner value in business. Where a member is connected with a company that provides medical services, he is enjoined to ensure that the organisation complies with the provisions of the code of ethics. Because this may prove difficult for him, the section advises that its members consider the inherent dangers of associating with such business enterprises. The section further contains a description of hospital

[49]But cf. S.6 MDPA 1988, which stipulates three categories of practitioners in the order of fully registered members, provisionally registered members and limited registered members.

[50]A similar stipulation is found in Rule 6 of the 1988 Rule.

facilities, defines a clinic, primary health care, medical centre, general, specialist and teaching hospital.

Rule 13 prohibits the practice of specialty without registration of specialist qualification with the Council. Rule 14 advises against the practice of self-medication save for minor ailment. Also, rule 15 advises a colleague who gives treatment to another not to expect the usual fee charged ordinary patients. Rule 16-18 deals with matters connected with good team spirit among doctors.

One of the finest innovations of the code is the provision of informed consent. This is contained in rule 19. Its inclusion is informed by recent judgments of the courts, especially *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*[51] in which the Supreme Court explicitly recognised the patient right to self-determination and autonomy.[52]The section contains an approved proforma consent form suggested for use in the treatment of patients. Interestingly it states that the majority age for consent purposes is 18.[53] Rule 20 carries further the frontiers of informed consent into the area of termination of medical services at the request of the patient or his relative. The patient right to terminate treatment even against good medical advice is preserved without prejudice if he returns for help to the same doctor.

Rule 21-24 deal with matters connected with modem biomedicine. Section 21 enjoins members to familiarise themselves with new frontiers in medical advancement.[54] It advises caution in research areas as cloning, genetic engineering, etc by doctors. In an era of information technology, members are advised to make appropriate arrangements for their patient's privacy and protect their personal information by rule 22. Rules 23 and 24 also advise necessary caution in assisted reproduction and HIV/AIDS treatment and research.

[51]Rule 7 of the Old Rules make a similar stipulation

[52](1999) 6 NWLR (pt. 786)1. The preamble of the 2004 Code of Ethics proclaims that the code was enacted to bring medical practice more in line with recent court decisions.

[53]Ibid.

[54]Ibid.

Part B of the Act

This part broadly regulates professional conduct, especially in relation to an allegation of infamous conduct in professional respect. Specifically, rule 26 states that a failure to adhere to rules 1-25 will amount to infamous conduct. Rule 27 requires all members to cooperate with the disciplinary organs of the profession. Rule 28 incorporates a duty of care on the doctor's part to his patient. It lists what shall amount to professional negligence. Recurrent negligence is viewed with severity.

Accordingly, a member who appears more than once before the Disciplinary Tribunal and is found guilty would not be given the option of merely being admonished. Rule 29 states that such a member shall be suspended for not less than six months. Where, however, he is habitually negligence, the practitioner's name shall be struck out of the list of members. Rule 31 incorporates the Helsinki 1994 Declaration on bio-medical research.[55]But besides this, it contains a proposal for the national drug approval process. It is a codification of ethically permissible limits to pre-clinical testing, new drug application, and the likes.

Part C of the Act

This part categorises the following as malpractice, namely; issuance of a false medical certificate, deceit to the patient with a view of extorting fees, aiding a non-doctor to practice medicine or dentistry, advertising and acting as a commission agent to health workers like a chemist, nurse etc., and allowing a member to be influenced by considerations of religion, race, politics, nationality or social standing in the treatment of a patient.

Part D of the Act

This part deals with what is considered an improper relationship with colleagues and patients. Rule 40 prohibits what can broadly be considered maintenance in law. A doctor must not instigate a patient to institute lawsuits against colleagues. A doctor is by rules 41 and 42 enjoined to refer a patient to a better-skilled or better-equipped facility if a patient's ailment is beyond his skill

[55]*Crawford v. Charing Cross Hospital* (1953) TLR 1, per Lord Denning

or facility.[56] Rule 48 treats as a serious offence, adultery and other improper association with a patient Sanction for breach is made to attract the removal of the member's name from the register. In this connection, any finding of fact made in proceedings in the High Court or an appeal from a decision in such proceedings shall be conclusive evidence before the Disciplinary Tribunal of the allegations against a doctor. For example, suppose in a divorce suit before the High court, a doctor is a cited party and adultery is proved against him in connection with a patient's treatment. In that case, that will constitute conclusive evidence of improper and indecent behaviour to the person of the opposite sex under the code for trial purposes before the Tribunal.

Part E of the Act

This part is concerned with particular aspects of private practice. By rules 49 and 50, only consultant and general practitioners of above ten years of practice engaged in full-time employment in the public service can own or run private practice during their spare time.

Part F of the Act

This part in the main proscribes self-advertisement and touting.

Part G of the Act

Under this part, conviction by a court of competent jurisdiction, which in the opinion of the Disciplinary Tribunal incompatible with the status of a doctor, may be sufficient ground for striking a member's name from the register. Rule 60 states that unlawful abortion shall constitute a grave offence. Any doctor who aids criminals in I is practice either by commission or omission will be guilty of infamous conduct.

Part H of the Act

Under this part, doctors are advised to avoid alcohol and drug offences and improper financial transactions and the purchase of

[56]Ibid.

patronage.[57] Rule 67 prohibits torture, whether by physical, psychological or chemical means. This prohibition would be unethical for a doctor to cause restrain a suspected drug trafficker to force his urine or excrement. It invariably follows that a doctor who allows himself to be used in executing a sentence of the court that amounts to torture nay be exposing himself to breach of the code, e.g. in the cutting of, say, the hand or limb of criminal pursuance to a court order, as in the case of Babagingabi in the Zamfara State.[58] Rule 68 prohibits doctor-assisted suicide or euthanasia. Rule 69 is an expression of the conditions which, in the opinion of the Council, may render it unsafe to practice the profession. These include senile dementia, drug addiction etc. Section 70 is the last Rule. It provides for the enforcement of sanction of the Council. If the Tribunal finds a member guilty, the sentence would be published in a gazette of the Federal Republic of Nigeria and four national newspapers. Notification of publication is to be deposited with the permanent secretaries of the federal and all states ministries of health and the National President of the Nigerian Medical Association or Nigerian Dental Association, depending on whether the erring member is a medical or dental practitioner. Where the member is merely suspended, the Registrar shall, in addition to the publication requirement, direct the suspended member to complete on a monthly basis an approved proforma to the effect that he maintains compliance with the sentence until the period of the suspension expires.[59]

Some scholars have expressed the view that generally, the profession has been too lenient with doctors on matters bordering on infamous conduct.[60] Whether that is the case or not,

[57]*Okonkwo v. MDPDT* (1999) NWLR (pt. 617)1, (1999) 6 NWLR (Pt. 785) 1.

[58]Rule 64-66

[59]The land of Babagingabi, who said to be amputated by a doctor on the orders of Sharia court, judge punishment to a conviction for stealing a cow in 2001.

[60]For an explanation of the word 'infamous conduct in a professional respect, see *Allison v. General Council of Medical Education* (1984)1 QB 750, *Doughly v. General Dental Council* (1989) AC 164, (1987) 3 All ER 843, *Marten v. Royal College of Veterinary Surgeon' Disciplinary Council* (1964) 1. QB1, (1965)1 All ER 949, *McEniff v. General Medical Council* (1980)1 All ER 461, (1980) 1 WLR 328;*McCoanv*. *General Medical Council*(1964)3 All ER 143, (1964) 1 WLR 1107; *Denloye v. Nigerian*

it depends on a distinction being drawn between serious and not too serious malpractice and whether the Council should concern itself not only with serious misconduct but also with cases not so serious. This is an area where balance is required. Some argue that it would be unfair to expose a competent doctor who acts incompetently in an isolated case to discipline. Good as the argument may be, it conversely may be unfair to leave the aggrieved patient, the victim of the isolated malpractice, with no remedy. This is what commends the New Zealand state-sponsored compensation regime.[61]

The Classical Illustration of this is seen in the Nigerian case of *Akintade v. Chairman, Medical and Dental Practitioners Disciplinary Tribunal*[62] where the concept of infamous conduct in professional respect is articulated. In this case, one *Chief (Mrs.) Florence Olusola Abe* (now deceased) was admitted at the Christian Health Centre, Ilesha, on 27th October 1997 for appendectomy, an operation carried out by *Dr Robert O. Akintade*, a registered Medical Practitioner, the only resident doctor at the Centre on 28th October 1997. The deceased was noted to be quite obese, whom on her history been taken, was found not to be diabetic, and the doctor did not order investigation, e.g. urinalysis, to exclude diabetes before operating on her. After the operation, complications set in and the patient's condition deteriorated from 31st October 1997 until 4th November 1997. The doctor referred the patient to Obafemi Awolowo University Teaching Hospital, where she died on the 6th of November 1997. The Obafemi Awolowo University Teaching Hospital certificate of death gave the primary course of death as AKA and secondary cause as septicaemia. The medical report also indicated that:

Dental Council, MDPDT V. Okonkwo(1999) 9 NWLR (pt. 617 1, (1999)6 NWLR (pt. 786)1

[61]New Zealand Accident Compensation Act, 1982 and Accident Compensation (Amendment) Act 1992; see also C.R. Cripps, Medical Practitioners Liability for personal Injury Caused By Negligence (1978) *NZLJ* 29; R. Mahoney, Informed Consent and Breach of the Medical Contract to Achieve a Particular Result; Opportunities For New Zealand's Patient Personal Injury Litigators to Peck Out of the Accident Compensation Closet (1985) 6 *Otago L. Rev.* No1, 103.

[62] (2005) 9 NWLR (Pt. 930)338 CA

"...death in this instance could be attributed to a combination of septicemia following faecal peritonitis fistula that followed the appendectomy she had in a private hospital. Uncontrolled diabetes and obesity probably also contributed." Consequently, the doctor was arraigned before the Medical and Dental Practitioners Disciplinary Tribunal on a two-count charge: The first charge consists of the following offences:

(a) failure to attend to the patient promptly;

(b) incompetence in the assessment of the patient by failing to diagnose her as a diabetic and failing to realise that the patient had post operations complication of faecal peritonitis;

(c) deficient treatment arising from inadequate pre-operative investigations, deficient operative procedure and poor and faulty postoperative management.
The second charge consists of:

(a) admission of the patient in the doctor's private hospital when he knew or ought to have known that the facilities therein were inadequate for the required treatment; and

(b) failure to refer the patient early to a better facility, especially when post-operative complications set in. The Court of Appeal set aside the 2nd charge but convicted the doctor for the offences listed in the 1st charge. He was therefore sentenced to suspension from practice for three months. The Council added that:

i. If it is shown that a medical man, in the pursuit of his profession, has done something which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competence, then it is open to the General Medical Council to say he is guilty of *"infamous conduct in a professional respect".* The question is not merely whether what a medical man has

done would be an infamous thing for anybody else to do, but whether it is infamous for a medical man to do it.[63].

ii. In determining the true nature of serious professional misconduct, the courts during the years had laid down a two-stage test, namely:

(a)did the doctors conduct fall short by an act or omission of the standard of conduct expected among doctors? If yes, then;

(c) was this failing serious?[64]

iii. It would, for instance, amount to serious professional misconduct if a doctor by public advertisement warns the public to avoid other doctors and recommends that members of the public should apply to him for medical advice or treatment.[65].

Conclusion

From the foregoing, the Medical and Dental Practitioner Council of Nigeria as a body corporate has done well to discipline any erring doctors who, in the course of his/her duty, had committed what could be called misconduct or infamous conduct in professional respect. Still, this research work has revealed that some ambiguities in the Act need clarification. For instance, the extent to which a doctor will/can treat patients before he/she entitles to payment or commensurate medical bills. Here, to what extent will a patient receive medical care/treatment that will command a certain amount of money to pay? What measure is the Medical and Dental Practitioners Council of Nigeria putting in place to ensure that prospective patients get value for their money paid to inform medical bills? This question alone, if not addressed by the Medical and Dental Practitioners Council of Nigeria, will cast doubt on their ability to provide a good

[63]*Allison v. General Council of Medical Education and Registration* (1894) 1 QB 750 (CA)
[64]*Doughty v. General Dental Council* (1988) AC 104; (1987) 3 All ER 843 (PC)
[65]*Allison v. General Council of Medical Education and Registration* (1894) 1 QB 750 (CA)

regulatory framework for the medical profession in Nigeria. In Nigeria, many people have argued that on most occasions, patients are not getting commensurate treatment for their health challenges from doctors, for instance in the earlier mention *Roy V. Kensington & Chelsea Family Practitioner Committee*, the plaintiff claimed that Dr Roy did not devote enough time for him and as such he did not get good treatment for his health challenges. Secondly, the code of conduct is silent on the minimum hours(s) or period a doctor must spend with any patient. As it is being practised in advanced countries like the United Kingdom and the United States of America, the number of hours or period a doctor is expected to spend in the Act will be clearly and expressly stated. Doing this will no doubt bring an improvement to our health sector in Nigeria.