

Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo

(2002) AHRLR 159 (NgSC 2001)

Medical and Dental Practitioners Disciplinary Tribunal v Dr John Emewulu Nicholas Okonkwo

Supreme Court, 2 March 2001

Judges: Belgore JSC, Onu JSC, Achike JSC, Uwaifo JSC and Ayoola JSC

Previously reported: [2001] WRN 1

Emmanuel Olayinka Ayoola JSC

[1.] Of the several issues raised by this appeal the central issue is whether a medical practitioner is guilty of infamous conduct when, in deference to the patient's religious objection to blood transfusion, he failed either to adopt such course of treatment; terminate his medical contract; or refer the patient to another health institution or another medical doctor.

[2.] The facts which led to this question are largely undisputed and can be briefly stated. Mrs Martha Okorie (the patient) and her husband belonged to a religious sect known as Jehovah's Witnesses who believe that blood transfusion is contrary to God's injunction. They take their stand from the scriptures. In Leviticus 17: 10-11 God said:

And I will turn my face against anyone, whether an Israelite or a foreigner living among you, who eats blood in any form. I will excommunicate him from his people. For the life of the flesh is in the blood, and I have given you the blood to sprinkle upon the altar as an atonement for your souls; it is the blood that makes atonement because it is the life.

[3.] They believe that the prohibition was passed to the Gentiles', that is non-Jews, in Acts 5:29 where it is stated that ye abstain from meats offered to idols, and from blood, and from things strangled, and from sexual immorality'. They believe that blood transfusion is eating' of blood.

[4.] Mrs Okorie, a 29-year-old woman, having had a delivery at a maternity hospital on 29 July 1991, was admitted as a patient at Kenayo Specialist Hospital for a period of nine days from 8 August to 17 August 1991. She had complained of difficulty in walking and severe pain in the pubic area. At Kenayo Hospital the diagnosis disclosed a severe ailment and a day after her admission blood transfusion was recommended. The patient and her husband refused to give their consent to blood transfusion. Dr Okafor, for the hospital, consequently discharged the patient, giving her a document in the following terms.

To whom it may concern: Re: Martha Okorie. The patient and her husband strongly refused blood transfusion despite appeals, explanations and even threats that she may die. The husband rather asked for his wife to be discharged and he took her away on 17/8/91.

[5.] Upon her discharge from Kenayo Hospital she was taken to Jeno Hospital by her husband on 17 August 1991. There he produced to Dr Okonkwo (the respondent) a card signed by the patient titled Medical directive/release' which reads as follows:

I Martha K Okorie, direct that no blood transfusions be given me, even though physicians deem such vital to my health or my life. I accept non-blood expanders, such as Dextran, saline of Ringer's solution, hetastarch. I am 29 years old and execute this document of my own initiative. It accords with my rights as a patient and my beliefs as one of Jehovah's witnesses. The bible commands: keep abstaining from blood' (Acts 15:28,29).

This is, and has been, my religious stand for 6 years. I direct that I be given no blood transfusions. I accept any added risk this may bring. I release doctors, anaesthesiologists, hospitals and their personnel from responsibility for any untoward results caused by my refusal, despite their competent care. In the event that I lose consciousness, I authorize witness below to see that my decision is held.

Sgd Martha Okorie Date: 23/2/91

Witness Sgd Loveday C Okorie - husband

Witness Sgd Ukwuoma CA - uncle

Printed in Nigeria.

[6.] In another document signed by the patient's husband, dated 17 August 1991 and titled Release from liability', the patient's husband stated as follows:

To Jeno Hospital, and the medical and nursing personnel having anything to do with the case of Mrs Martha Okorie (my wife). You are hereby notified and instructed that I do not wish any transfusion of whole blood, blood plasma, packed cells blood fractions or blood derivatives to be used in the treatment of this patient. I regard the transfusion of blood and blood products as unnecessarily dangerous treatment producing too many bad effects to justify the risk. It is also contrary to my faith as one of Jehovah's Witnesses. I recognise and understand that the attendant physicians have advised that they are of [the] opinion that blood transfusion is necessary perhaps [to] save the life of the patient. I do not share their opinion and adhere to the instructions given in this notice. This restriction leaves open the use by transfusion or otherwise of Ringer's lactate solution, glucose or other volume expanders not derived from blood. This matter has been carefully considered by me and my instructions are not going to change because I or the above named patient is unconscious. The hospital, the medical and nursing

personnel caring for the above patient are hereby released from responsibility and liability of any and all untoward effects which flow from the decision not to accept the treatment prohibited in this release. Dated this 17th day of August, 1991.

Sgd Loveday Okorie (husband)

Patient, Parent or Guardian.

[7.] The respondent proceeded to treat the patient without transfusing blood. However, the patient died on 22 August 1991.

The charge

[8.] The respondent was charged before the Medical and Dental Practitioners Disciplinary Tribunal (the tribunal) in 1993 in two counts. In the first count he was charged with attending to the patient in a negligent manner and thereby conducting himself infamously in a professional respect contrary to medical ethics' and punishable under section 16 of the Medical and Dental Practitioners Act (the Act). In the second count he was charged with acting contrary to his oath as a medical practitioner and thereby conducting himself infamously in a professional respect contrary to the same section of the Act.

The allegations in the first count were that:

(a) [A]lthough it was clear from the referral letter from Kenayo specialist hospital, Onitsha, where the patient had been previously admitted, that the patient was severely anaemic, which said diagnosis you confirmed upon the patient being admitted in your hospital, you nevertheless made no plans and in fact failed to transfuse blood to the patient until she died on 22/8/91;

(b) [A]lthough you claimed inhibition for your failure to apply an obviously correct treatment to the patient, you failed to transfer the patient to a bigger centre where such inhibition would not operate to the patient's disadvantage.

[9.] In regard to the second count the allegations were that he allowed religious consideration to influence his treatment of the patient in the following circumstances:

(a) [I]t was clear that only blood transfusion could possibly save the patient's life, but

(b) [B]ecause of your religious belief against blood transfusion as a Jehovah's Witness yourself, you readily agreed with the patient's husband not to transfuse blood, even when the patient's relations pleaded with you to the contrary.

The trial

[10.] The respondent pleaded not guilty to the charge. At the trial, witnesses who gave evidence for the prosecution were an officer of the Medical and Dental Council (the council), who tendered certain documents, the uncle of the patient, and the mother of the

patient. Apparently, the last two were the persons who lodged a complaint against the respondent. The respondent, who gave evidence in his own defence, testified that the patient and her husband objected to blood transfusion and persisted in their objection even after he had made them to understand the gravity of their decision. It was at that stage that the patient's husband signed the document (exhibit G) releasing him and his hospital from liability. He gave the following evidence concerning his willingness to transfer the patient to another hospital:

I then invited the husband to my office and made it clear to him that I am not used to trouble and that I think the best thing I was going to do was to move them over to the Teaching Hospital, so as to wash my hand off the trouble. And the husband said to me that he was no more prepared to go to anywhere and that he had confidence that whatever my best comes to he would take it.

[11.] Under cross-examination he said that had the patient consented to a blood transfusion he would have arranged for it. He gave evidence that he was not influenced by any consideration other than the patient's refusal to give consent for a blood transfusion in his failure to provide a blood transfusion. He said that he had obeyed the request of the patient's husband not to transfer the patient despite his offering them a transfer. The patient's husband, Loveday Okorie, the only other witness for the defence, corroborated the evidence of the defendant in material particulars, particularly in regard to the refusal of the patient and himself to consent to a blood transfusion even after being warned by the defendant of the possible consequence of their decision.

The judgment of the tribunal

[12.] The tribunal proceeded on the basis that the respondent was being charged with medical negligence arising from the fact that he failed to administer a life-saving measure to his patient'. The life-saving measure, the tribunal stated, was a simple blood transfusion'. What the tribunal regarded as the main issue in the case was what course of action should a doctor take who had been denied informed consent to carry out a medical life-saving measure?

[13.] The tribunal referred to a published code of ethics' (code) and stated that the code enjoined a doctor not to allow anything, including religion to intervene between him and his patient and that he must always take measures that lead to the preservation of life'. Still claiming to rely on the code, the tribunal went on to say:

When therefore he is faced with a dilemma arising from the refusal to grant informed consent our Code of Ethics prescribes that a doctor faced with such dilemma has 2 options: (a) he can terminate his medical contract or; (b) refer him or her to another institution where necessary measures for the preservation of life may be taken.

[14.] Having thus set out the basis on which it would proceed, the tribunal made the critical finding that the respondent colluded with the patient to deny life on religious grounds. Being of the opinion that the consideration which influenced the respondent's treatment of the patient was the respondent's religious belief, the tribunal went on to hold:

We found therefore that although a doctor as well as anybody else may hold to his religious beliefs he must not allow those religious beliefs to lead ultimately to the loss of life. A blood transfusion does not guarantee life, but it is held by the whole profession that it can be a life-saving measure in certain circumstances, as in this case. For a doctor to collude with those who will deny this life-saving measure on grounds of religion is unethical to the medical profession. In the event the doctor waited and watched over the patient until she died 4 days later. That is, without giving other doctors and other health institutions an opportunity to obtain the consent and administer the correct treatment.

[15.] The tribunal concluded its judgment by holding that the respondent was not criticised for holding this religious belief or for respecting the religious belief of others, but for holding onto the patient knowing full well that the correct treatment could not be given in the face of failure to obtain consent. The tribunal found the respondent guilty on the 3 counts', and suspended him for a period of six months on each of the charges' to run concurrently.

The appeal to the Court of Appeal

[16.] The respondent appealed to the Court of Appeal. In that Court three main questions arose, namely: (1) whether the allegations in the charge amounted to criminal offences so as to take them out of the jurisdiction of the tribunal; (2) whether failing to allege in the charge that the conduct of the respondent constituted a breach of the rules of professional conduct affected the validity of the charge; (3) whether the tribunal should have found the respondent guilty when it had itself found that the patient and her husband refused to give consent to blood transfusion. The Court of Appeal (Oguntade, Aderemi and Nzeako JJCA) held that the charge as laid in the first count connoted that the inaction on the part of the respondent amounted to negligence leading to the death of the patient and was an allegation of a criminal offence. In the result it held that the tribunal had no jurisdiction to try the allegations in the first count and that its decision was for that reason null and void. In regard to the second count, being of the view that no criminal offence was charged in that count, the Court of Appeal held that the tribunal had jurisdiction to try the count.

[17.] In regard to the second issue the Court below held that the failure to charge the respondent with the violation of any of the rules made pursuant to section 1(2)(c) of the Act was fatal to the charge. Nzeako, JCA, who delivered the leading judgment of the Court of Appeal reasoned, rightly, that a party who is brought to court is entitled to know the claim or the charge which he is called upon to answer. But she went further to hold that since the charge did not allege contravention of any particular code of ethics and the code did not prescribe what a doctor should do when faced with a dilemma arising from the refusal by the patient of informed consent, the respondent did not have a fair hearing.

[18.] Although on the basis of the determination of the second issue the Court below set aside the decision of the tribunal in its entirety, it took a wise and helpful course in considering the third issue as well. On that issue it was of the view that when the tribunal decided that the respondent was guilty because he held onto the patient knowing full well that the correct treatment could not be given in the face of failure to obtain consent, it

deviated from the charge. In the opinion of the Court below the real question was whether a medical practitioner should proceed to administer the medical measure refused by the patient, without the patient's informed consent. It was of the view that the combined effect of section 35 and section 36(1) of the 1979 Constitution, dealing with freedom of conscience and freedom of expression respectively, was that an adult of sound mind has a right to choose what medical treatment made available to him he could accept or refuse. The Court below criticised the code of ethics for failing to pin down on the conflict between the right of a patient to decide on what medical measures to agree to and the doctor's code of ethics'. To support its conclusion it cited the Canadian case of *Malette v Shulma* 47 DLR (4th ed) 18a and the English case of *Didaway v Board of Governor Bethlehem Royal Hospital* [1985] 1 AC 871.

[19.] The Court of Appeal, having resolved all the issues substantially in favour of the defendant, allowed the respondent's appeal and set aside the decision of the tribunal. The tribunal appealed to this Court.

This appeal

Preliminary objection

[20.] The tribunal raised eight grounds of appeal by its notice of appeal dated 12 July 1999. From these grounds of appeal six for determination were formulated by counsel for the tribunal. These are contained in the appellant's brief of argument filed on 29 December 1999. The respondent's counsel, for his part, formulated five issues for determination, distilled also from all the eight grounds of appeal. They are contained in the respondent's brief of argument filed on 11 February 2000.

[21.] Notwithstanding that counsel for the respondent had, in the respondent's brief, argued all the issues formulated as arising from the eight grounds of appeal, the defendant, by the notice of preliminary objection filed on 14 November 2000 by his counsel, objected to the fifth, seventh and eighth grounds of appeal on the ground that they did not involve questions of law alone and that requisite leave to appeal had not been obtained. Ground six was objected to on the ground that it was vague and its purport was unclear.

[22.] Without stating the particulars the grounds of appeal to which objection have been taken are as follows:

(5) The Court of Appeal erred in law when it held that for a charge against an erring medical practitioner to be valid it must state clearly the particular code of ethics that has been violated.

(6) The Court of Appeal misconceived the decision of the tribunal in relation to the charge and thereby came to a wrong conclusion when the Court of Appeal stated as follows:

The point being made by the appellant, not therefore answered by the respondents, is simply that the tribunal found that blood transfusion was not done

because the patient and her husband had denied informed consent. They should therefore not have found the appellant liable in counts 1(a) and count 2, charging him with making no plans to transfuse blood and not transfusing blood. For it was the tribunal that stated as follows: We criticised the defendant doctor not for holding this religious belief But for holding onto the patient knowing fully (sic) well that the correct treatment cannot be given in the face of failure to obtain consent.' The statement by the tribunal has clearly jettisoned the charge or blame of failure to transfuse blood or failure to make plans to transfuse blood as set out in the charge. The tribunal has replaced it with a new blame, viz: that the appellant failed to take certain actions which he ought to [have], when he was faced with a dilemma arising from the refusal to grant informed consent', and that he held onto the patient knowing full (sic) well that the correct treatment cannot be given in the face of failure to obtain consent'.

(7) The Court of Appeal failed to appreciate the submission in the respondent's brief of argument, and thereby came to a wrong conclusion when the court stated:

For the respondent, it was submitted that the appellant's excuse that he was denied informed consent to transfuse blood by both the patient and her husband was an after-thought (see page 8 of the written brief) That submission for the respondent as to after-thought' does not answer the serious question raised in issue no 3, arising from the decision (for) [of] the tribunal which had indeed found that the appellant did not transfer (sic) blood because of the refusal of the patient and her relations to give consent

(8) The Court of Appeal misconceived the issue before the court when it held as follows:

Be that as it may, in view of the decision of the Tribunal, it has not been considered worthwhile in considering this appeal to go into the details of the evidence relating to failure to transfuse blood, who was responsible for the failure to transfuse blood, etc as the respondent's counsel was doing.

Rather, the legal issue which seems very important and requiring some attention is the medical and legal status of informed consent of a patient vis-à-vis the professional duty of the medical practitioner, in the face of studied refusal by a patient and/or his guardian and next-of kin, as the case may be. Should the medical practitioner proceed to administer the medical measure refused without that consent?

[23.] In regard to grounds 5, 6, 7 and 8 the issues formulated by counsel for the respondent were respectively as follows:

Issue 2: Whether the Court of Appeal was right in holding that the tribunal lacked jurisdiction to try the respondent for offences not known to the rules of professional conduct for Medical and Dental Practitioners in Nigeria.

Issue 3: Whether the Court of Appeal was right in holding that the tribunal replaced the counts 1(a) and 2 of the charge with a new blame.

Issue 4: Whether the Court of Appeal was right in rejecting the submission in the respondent's brief (appellant in the court below) as an after thought'

Issue 5: Whether the Court of Appeal was right to hold that the issue in the instant case is the legal status of informed consent of a patient vis-à-vis the professional duty of the medical practitioner in the face of studied refusal of a patient and/or his next of kin as the case may be

[24.] Section 233(2)(a) of the 1999 Constitution is clear in its provisions that:

An appeal shall lie from decisions of the Court of Appeal to the Supreme Court as of right in the following cases: (a) Where the ground of appeal involves questions of law alone, (from) decision in any civil or criminal proceedings before the Court of Appeal.

The important consideration in the determination of the nature of a ground of appeal is not the form of the ground but the question it raises. A ground of appeal involves a question of law alone when the complaint of the appellant in that ground can be dealt with without resort to determination of any question of fact, that is to say, when the facts are agreed or admitted, or when determination of the ground is not dependent on any facts to be proved. It is not wise to attempt a list of instances in which a ground involves a question of law alone.

[25.] It suffices to say that there is now a growing list of authorities affording guidance to the determination of the nature of a ground of appeal. The most often cited is *Ogbechie & Ors v Onochie & Ors* [1986] vol 7 NSCC 443 [no 1]. However, in each case in which an objection such as in this case is raised to the ground of appeal the Court still has to examine the ground and determine its nature. Recently, objection was raised to grounds which raised questions that are broadly similar to the questions raised by the grounds objected to in this appeal in the case of *Shanu & Anor v Afribank (Nigeria) Ltd* [2000] 13 NWLR (Pt 684) 392. In that case this Court held thus:

Where the ground of appeal complains that the tribunal has failed to fulfil an obligation cast on it by law in the process of coming to a decision in the case, such a ground would involve a question of law, namely: whether or not there is such an obligation or whether what the tribunal did amounted to an infraction of such obligation, provided that all the facts needed are there on the record and are beyond controversy.

[26.] In the present case it is evident that ground 5 raises a question of law alone. Whether a charge is deficient in its contents or not involves a question of law alone. In regard to grounds 6, 7 and 8 no question of fact is to be resolved in order to determine whether an appellate tribunal misconceived the decision of a lower one or whether a tribunal failed to appreciate the submission of counsel. What is involved in the

determination of such question is an interpretation of the judgment under review in the light of the issues in the case or of the submissions alleged to have been misconceived.

[27.] When a party objects to a ground of appeal on the ground that it raises a question of fact or mixed fact and law and that requisite leave has not been obtained, the court will determine the question on a reasonable understanding of the nature of the ground of appeal and not on what the party raising the object may have misconceived to be the question involved in the ground. In the present case, it is clear that the respondent's counsel's understanding of the grounds of appeal objected to, as portrayed in the notice of preliminary objection, does not represent the true purport of the grounds of appeal. Having regard to the issues formulated by the counsel himself in the respondent's brief, which are all issues of law, the inescapable conclusion is that the preliminary objection is utterly disingenuous.

[28.] Before I part with the aspect of the appeal, it is expedient to note that learned counsel for the tribunal was absent at the hearing of the preliminary objection and could therefore not proffer oral argument thereon. However, later, he forwarded a written brief on the objection. It was not necessary to consider the written brief for the purpose of dealing with the preliminary objection since the objection is completely without substance. The preliminary objection is overruled.

The issues for determination

[29.] Although six issues for determination were formulated by counsel for the tribunal and five issues by the counsel for the defendant, the main issues that arise in this appeal are three, namely: (i) whether the tribunal had no jurisdiction to try count 1 because it disclosed allegation of criminal offences; (ii) whether in regard to both counts the proceedings are a nullity in that particulars of code of ethics that the respondent was alleged to have infringed were not disclosed in the charge; and (iii) whether there was a failure to understand the charge itself by the tribunal and, the issue tried by the tribunal by the Court below.

Did the tribunal have jurisdiction?

[30.] The Court below held that the tribunal had no jurisdiction to try the offence charged in count 1 because, as stated in the leading judgment delivered by Nzeako, JCA, the defendant was charged with criminal negligence in count 1. In her view, the charge connoted that the inaction on the part of the appellant amounted to negligence that led to the death of the patient. The offence disclosed in count 1 the Court below held was an offence under section 303 of the Criminal Code, punishable under section 304(5), or an offence under section 343(1)(e).

[31.] Realising that there was no allegation in count 1 that the respondent either by act or by omission caused the death of the deceased, the Court below, per Nzeako, JCA, held that the inference can be drawn that is the imputation'. The learned justice said:

Where however a charge and evidence impute that the negligence by way of omission to act, or not acting correctly led to the death of the patient, this implies

negligence which may be charged under section 303 of the Criminal Code and 343(1)(e).

[32.] Relying on *Denloye v Medical and Dental Practitioner Disciplinary Committee* [1968] 1 ALL NLR 306, the Court below held that the tribunal was wrong to have proceeded to try offences punishable under the Code. In *Denloye's* case the defendant was tried by a tribunal on five counts of infamous conduct. In the first he was alleged to have neglected a patient who was seriously ill and for whose treatment he was responsible, while several criminal offences covered by section 82 and 89 of the Criminal Code were charged in the remaining four counts. He was found guilty and his name ordered to be removed from the medical register. On his appeal to the Supreme Court it was argued by his counsel, relying on section 22(2) of the 1963 Constitution, that it was not competent for the tribunal to try an offence chargeable under the Criminal Code. This Court held that the allegation in the first count was not of such an offence. However, in regard to the other counts which it found to have charged offences covered by the Criminal Code, it held that the tribunal had no jurisdiction to try them. Its decision was not based on section 22(2) of the 1963 Constitution but on what it considered to be intendment of the Act. Ademola, CJN, delivered the judgment of the Court and said:

Under the English Medical Act 1956, charges of this nature which are covered by the criminal law are not dealt with under the Act in the first instance, but are left to the courts. After convictions have been obtained in the courts, disciplinary actions would follow. We have no doubt in our minds that this is the intention in this country as well. [At 264.]

At 265 he said:

In effect where the unprofessional conduct of the practitioner amounts to a crime, it is matter for the courts to deal with; and once the court has found a practitioner guilty of an offence, if it comes within the type of cases referred to in section 13(1) (b), then the Tribunal may proceed to deal with him under the Act (*Italics supplied*).

[33.] In *Sokefun v Akinyemi & 3 Ors* [1980] 5-7 SC 1 and *Garba & Ors v University of Maiduguri* [1986] 1 NSCC 245 substantially the same conclusions were arrived at, albeit, by a slightly different route. This Court decided in those cases the broad question of the jurisdiction of an administrative disciplinary tribunal to try allegations of a criminal nature on the basis of the exclusive judicial powers vested in the courts or tribunals established by law as provided in section 6(1)(2), and section 33(1) and (4) of the 1979 Constitution.

[34.] Constitutional provisions apart, it is clear that the tribunal with which the present case is concerned is set up to try specified offences under the Act. It has no jurisdiction to try criminal offences at large. The function of the tribunal, established under section 15 of the Act, is to consider and determine any case referred to it by the panel established under subsection 3 of section 15 and any other case of which the tribunal has cognisance under the Act. The function of the Medical and Dental Practitioners Investigation Panel, so far as is relevant to this case, is to conduct preliminary investigation into any case where it is

alleged that a registered person has misbehaved in his capacity as a medical practitioner, or should for any other reason be the subject of proceedings before the tribunal. Section 16(1) contains provisions for award of disciplinary measure after conviction of the practitioner for a criminal offence. Where infamous conduct cannot be established without proving facts that would amount to an offence covered by the Criminal Code the tribunal should yield to the criminal courts established for the trial of such offence. To hold otherwise may lead to a conflict of verdicts, where a tribunal had first tried the matter and found the practitioner not guilty of infamous conduct, while on the same set of facts a criminal court finds him guilty of a criminal offence and convicts him; or vice versa. That may lead to the incongruous situation of the tribunal having to revisit the matter and act pursuant to section 16 in case of a conviction by the criminal court. Where the criminal court acquits a practitioner who has been found guilty by the tribunal and penalised, some complications may arise.

[35.] The recent English case of *Law Society v Gilbert*, *The Times* 12 January 2001, affords a comparison in approach. In that case a solicitor who had admitted conduct unbefitting a solicitor before a disciplinary tribunal and has been suspended from practice for three years, was subsequently convicted of offences of dishonesty on the basis essentially of the same facts. The Law Society then brought a second set of disciplinary proceedings based on that conviction. It was held by the English Queen's Bench Divisional Court that the second set of disciplinary proceedings was not an abuse of process. As reported, Lord Justice Woolf, CJ, said:

Disciplinary proceedings brought by the Law Society in relation to its members were brought primarily not with the intention of imposing punishment on the solicitor in question, but with the important purpose of maintaining the standards of the profession. The important feature of the present case was that when the first Tribunal considered the matter, it did not know that Mr Gilbert would subsequently be convicted. That was not a matter which was before the first tribunal. It would have been open to the Law Society to await the outcome to any criminal proceedings before commencing the first set of disciplinary proceedings. However, such a course had disadvantages. The Law Society would have had to defer for maybe a substantial period before the bringing of disciplinary proceedings. That could have meant that the public was put to risk.

[36.] Notwithstanding the case of *Law Society v Gilbert* to which reference has just been made merely for the purpose of comparison of approach, our law stands as decided in *Denloye's case*. However, it may well be worthwhile to consider, should an appropriate occasion arise, how best to deal with the problems that may arise from the inability of the disciplinary body to enforce discipline with the necessary dispatch in the face of the slowness of our criminal justice system. Be that as it may, the tribunal would have had no jurisdiction to try count 1 if that count had charged a criminal offence covered by the Criminal Code.

Was the charge of an offence covered by the Criminal Code?

[37.] Having agreed with the Court below that the tribunal has no jurisdiction to try offences covered by the Criminal Code, the question that arises is whether count 1 charge is such an offence. It is evident from the judgment of the Court below that it is only by a process of reasoning by implication that it was able to hold that such an offence was charged. Several passages from the leading judgment delivered by Nzeako, JCA, show this. Some of the passages are as follows:

There can be no doubt that this court charges the accused of negligence. What is the degree of negligence can be read from the particulars and that is what determined whether it be criminal negligence, or not.

The use of the word negligent' in the charge may sound general in nature but when read with the particulars, it seems to lead to an inference that the failure of the appellant to transfuse blood or to transfer the patient to a bigger hospital operated to the patient's disadvantage. What disadvantage? The answer is that it led to death. In other words, the charge as laid connotes that the in-action on the part of the appellant amounting to negligence led to the death of Martha Okorie.

In another passage the Court below said:

Although it is not implicitly (sic) stated that the omission was the cause of the death of the patient, the inference can be drawn that is the imputation.

Finally, after considering the materials which the tribunal considered to reach its conclusion in the matter, the learned justice said:

In my view, all the foregoing point to the nature of the charge of negligence influenced by the appellant's religious faith resulting in the death of Martha.

She also emphatically stated thus:

It is not entirely correct, as submitted by learned respondent's counsel in his brief, that the appellant was not charged with killing or causing the death of the patient, but for attending to her in a negligent manner'. He is by implication charged with causing her death (italics supplied).

[38.] Having made pronouncements as above, the learned justice of the Court of Appeal concluded that section 303 of the Criminal Code encompassed the charge' and that the offence was punishable under section 304(5). She said the same charge could be made under section 343(1)(e).

[39.] Section 303 of the Criminal Code provides as follows:

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 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.

[40.] Section 303 states the duty of persons doing a dangerous act such as administering surgical and medical treatment and their responsibility for the consequences that may result to the life or health of any person by reason of any omission to observe or perform that duty. The section does not by itself create an offence but creates a duty where it would have been doubtful whether or not one existed in criminal law. It establishes liability for consequences of the breach of that duty. In circumstances where it is applicable it makes negligence the basis of criminal liability for offences against the person (excluding murder) where the need to establish intention, knowledge and such mental elements as the basis of liability would have been required.

[41.] The Court below seemed to have realised that the section does not by itself create an offence when it tried to invoke section 305A(4) as the punishment section. In doing this the Court below erred because section 305A(4) is applicable only to an offence against any of the provision[s] of this section', that is section 305A.

[42.] Section 303 does not dispense with the need to allege in a charge the causal connection between an alleged breach of duty of reasonable skill and care and its consequence, nor does it dispense with the need to charge a specific offence.

[43.] Section 343(1)(e) of the Criminal Code provides that:

(1) Any person who in a manner so rash or negligent as to endanger life or to be likely to cause harm to any person ... (e) gives medical or surgical treatment to any person whom he has undertaken to treat; is guilty of a misdemeanor and is liable to imprisonment for one year.

[44.] In a charge under section 343(1)(e) the prosecution must allege that the offender (1) gave medical (or surgical) treatment to a person whom he has undertaken to treat; (2) that he did so in a manner so rash and negligent; (3) as to endanger life or to be likely to cause harm. Rashness and negligence in this instance connote a disregard for life and safety of the person treated. The manner of treatment itself must be the likely cause of danger to life or harm to the person treated. It is not part of our system of criminal justice that the contents of a charge should be the subject of speculation and inference. The law is clear beyond peradventure that the essential elements of the offence should be disclosed in the charge. Section 33(6) of the 1979 Constitution provided, and now section 36(6) of the 1999 Constitution provides, that every person charged with a criminal offence is entitled, among other things, to be informed in detail of the nature of the offence. Where a charge before a disciplinary tribunal is, as framed, adequate for the purpose of the disciplinary proceedings and contains enough information for the purpose of such proceedings, it is not right to impute an intention in the framers of the charge to charge an offence not expressly mentioned in the charge. A simple test of the validity of the conclusion reached by the Court below on this issue, I venture to think, is whether on the charge as framed, and not as it could be, and should have been, framed, had the trial been before a criminal court, the respondent could have been found guilty of an offence under section 343 (1)(e) of the Criminal Code, whether read alone or with section 303. I am satisfied that he could not.

[45.] Counsel for the respondent submitted that the charge in the first count was an offence under section 343(1)(e) of the Criminal Code; murder under section 316 and manslaughter. That cannot be a right or sensible way of looking at any charge, nor of looking at one framed in consonant with the mandate of the tribunal, which was to consider a case of infamous conduct in a professional respect referred to it by the panel. The mere mention of negligence in the charge does not reasonably lead to the inference which the Court below strained to put on the charge.

[46.] From the foregoing it is clear that learned counsel for the tribunal was right when he submitted that count 1 of the charge did not imply and could not legally have implied any criminal offence on the part of the respondent. It is indeed difficult to see the difference in substance between the first count in this case and the first count in the case of Denloye (supra). The Court of Appeal was in error in holding that the tribunal lacked jurisdiction to try count 1 of the charge.

Should the charge have alleged a breach of the Rules of Professional Conduct?

[47.] The Court below held (per Nzeako, JCA) that because it was not alleged that any particular code of ethics' has been breached and that the rules or code of ethics' did not state what a medical practitioner faced with a dilemma arising from the refusal to give informed consent to a course of treatment should do, that the respondent did not have a fair hearing. For these reasons the decision of the tribunal was set aside.

[48.] Learned counsel for the tribunal has argued that the framers of the Act had intended to adopt the common law definition of infamous conduct as declared in *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750, 760-761 and *In Re: Idowu: A Legal Practitioner* [1971] Vol 7 NSCC 147; [1971] 1 All NLR 128, 136. Furthermore, he argued that no form is prescribed for a charge under the Act.

[49.] For his part, learned counsel for the respondent quoted rule 9 of the Rules of Professional Conduct as follows:

All registered doctors and dental surgeons shall in all areas of their professional conduct, practice and comportment, in professional and other relationships with patients and other persons be guided and bound by the rules contained in these codes. Any registered practitioner who, after investigation and trial during which he is given every opportunity to defend his actions and conduct, is found to have contravened these rules by the Disciplinary Tribunal of the Medical and Dental Council of Nigeria shall be guilty of professional misconduct.

[50.] Relying thereon he submitted that the provision of section 16(1)(a) of the Act and of the Rules must be read together and that, doing so, a charge of infamous conduct in a professional respect must allege a violation of specific provisions of the Rules.

[51.] The term 'infamous conduct' is wide. It is futile, in the absence of a statutory definition limiting its ambit, to restrict its meaning within the confines of a code of ethics. In *Sloan v General Medical Council* [1970] 2 All ER 686, Lord Guest, at 688, put it this way:

There are no closed categories of infamous conduct and in every case it must be a question for the committee to decide first whether the facts alleged have been proved, and second whether the appellant was in relation to those facts guilty of infamous conduct in a professional respect.

[52.] A code of ethics, no doubt, sets a standard of professional conduct. An infraction of the code may amount to professional misconduct but not every infraction amounts to infamous conduct in the sense in which that term has been used in *Allinson v General Council of Medical Education and Registration*; or *In Re Idowu: A Legal Practitioner*, or as it is generally understood. In the case of *Allison* infamous conduct' in relation to a practitioner was described as conduct regarded as disgraceful or dishonourable by his professional brethren of good repute and competency'. In *Re Idowu*, this Court cited with approval the opinion expressed in the Australian case *Ex parte Medical Practitioner's Act* [1965] NSW 30 that the expression infamous conduct in any professional respect' refers to conduct which, being sufficiently related to the pursuit of the profession, is such as would reasonably incur the strong reprobation of professional brethren of good repute and competence. It may well be added that in the Australian case, the Australian court went on to hold that the word infamous' must be understood by reference to the context of professional disapprobation and conduct may be infamous either in general estimation or merely in the special professional sense or in the professional sense accompanied by some element of moral turpitude. (See 33 *The Digest* no 2369 at page 297.)

[53.] In rule 9 of the Rules of Professional Conduct referred to by counsel for the respondent, an infraction of the rules was to be regarded as professional misconduct', while the Act, apart from the penalty that can be imposed consequent to conviction of a registered person, provided for the penalty to be imposed on a registered person who is adjudged by the disciplinary tribunal to be guilty of infamous conduct in any professional respect. There is thus an apparent incongruity in the Rules and the Act. However, it is generally accepted that the words infamous conduct' mean the same as serious professional misconduct'. A note to that effect is contained in 33 *The Digest* p 2360 as follows:

The words serious professional misconduct' first enacted in the Medical Act 1969 as an amendment to the original phrase infamous conduct in any professional respect' (Medical Act 1956 s 33(1)(b) and earlier enactments) were not intended to change the law but to replace outdated phraseology.

[54.] A breach of the rules may amount to misconduct, but not every conduct that may be open to objection will amount to infamous conduct. To attract that classification the conduct must be a serious misconduct. By way of analogy, in *Davies v Davies* [1960] 3 All ER 248, 253-254, it was held that:

If in conducting proceedings, a solicitor follows a course which, although possibly open to objection, does not infringe any clear practice, what he does will not amount to conduct unbecoming a solicitor.

[55.] From what I have said, it should be clear that the myriad of circumstances that may constitute infamous conduct cannot be exhaustively set out in a code. The proper

approach is first to ask what facts have been alleged. The next step is to ascertain whether they have been proved. When facts alleged have been proved, the next step is to determine whether they amount to infamous conduct. When, therefore, the respondent was charged with infamous conduct and particulars were given in the charge of the acts or omission alleged to amount to infamous conduct that, in my judgment, is sufficient. The respondent could only be pronounced guilty and penalised pursuant to section 16(1) and (2) of the Act if the facts alleged and proved lead reasonably to his being adjudged guilty of infamous conduct in any professional respect'. At best, reference to particular breaches of rules in the particulars of the charge is an optional matter of detail which can be dispensed without injustice to the person charged. What is important is that the person charged should have sufficient notice of the acts alleged to have been committed by him which add up to infamous conduct'.

[56.] Furthermore, the law is clear that conviction which states a known offence with incomplete particulars can be upheld where the defence was not misled and no substantial miscarriage of justice has taken place: Commissioner of Police v Ohoyen [1964] vol 7 NSCC 217, R v Iyoma [1962] vol 2 NSCC 295. For these reasons, I am unable to agree with the conclusion arrived at by the Court below that the proceedings before the tribunal were a nullity. The respondent did not complain at the trial about any deficiency in the particulars supplied. Even if the charge should have specified, but had omitted to specify, the rule breached, the Court below should have regarded such defect in the charge as an irregularity and determined whether it had occasioned a substantial miscarriage of justice. I cannot see how any miscarriage of justice had been occasioned to the respondent who had shown that he was misled by the charge. I hold that the Court of Appeal was in error in holding that the charge as framed was defective and that the decision of the tribunal should for that reason be set aside.

Did the tribunal and/or Court below confuse the issues?

[57.] The first arm of the charge was that the respondent failed to transfuse blood to the patient, and the second arm was that he, having claimed inhibition to apply an obviously correct treatment to the patient, failed to transfer the patient to a bigger centre. The second charge was that the respondent allowed his own religious belief against blood transfusion to influence his treatment of the patient and thereby acted contrary to his oath as medical practitioner. The tribunal rightly summed up the main question when it stated that: The whole issue therefore boils down to a course of action by a doctor who has been denied an informed consent to carry out a medical life-saving measure.' The tribunal proceeded to answer the question by considering what it regarded as the two options open to a medical practitioner faced with such a situation relying, as it claimed, on the code of ethics' of the medical profession. Its statement of those two options has been set out earlier in this judgment.

[58.] The tribunal proceeded to make the following finding:

- (i) The respondent colluded' with the patient to deny life on religious grounds and such is [in]compatible with a doctor's duty.

(ii) The human rights of the patient must give way to legislation made in respect of public order and public health.

(iii) The respondent should not have colluded' with those who will deny life-saving measure on grounds of religion as such is unethical to the medical profession.

(iv) The respondent is not criticised for holding the material religious belief or for respecting such belief or other, but for holding onto the patient knowing fully well that the correct treatment cannot be given in the face of failure to obtain consent.'

[59.] I may well add that in passing sentence the tribunal recognises the difficulty which the doctor must have had in reconciling his own religious beliefs as well as the patient's religious beliefs with his duty as a medical doctor.'

[60.] In the Court of Appeal counsel for the respondent took the point that the tribunal was wrong to have found the respondent guilty on counts 1(a) and 2 of the charge when it had found as a fact that the respondent could not have transfused blood in the absence of the patient's consent. The Court of Appeal agreed with this view and went on to say that:

The Tribunal has clearly jettisoned the charge or blame of failure to transfuse blood or failure to make plans to transfuse blood as set out in the charge. The Tribunal has replaced it with a new blame viz; that appellant failed to take certain actions which he ought to [have], when he was faced with a dilemma arising from the refusal to grant informed consent', and that he held onto the patient knowing fully well that the correct treatment cannot be given on the failure to obtain consent'.

[61.] Being of the view that the only issue in the case was whether the medical practitioner should proceed to administer the medical measure refused without that consent' the Court below held that:

[I]f a patient refuses to give informed consent, the law seems to be that the medical practitioner will not proceed to administer the medical measure or treatment eg in the case of surgery or blood transfusion as in the present case.

It relied for the view on the Canadian case of *Melette v Shulman* 47 DLR [4th Ed] 18 and the English case of *Sideway v Board of Governor Bethlehem Royal Hospital* [1985] 1 AC 871; [1985] All ER 643.

[62.] The Court of Appeal acknowledged that the tribunal limited itself to proposing optional measures which a medical practitioner caught in the web of the conflicting duties and rights, as Dr Okonkwo was, ought to adopt'. However, that Court disposed of that aspect of the matter by holding that those measures have not been part of the rules or code already enacted by the council pursuant to the Act. Having noted, in effect, that the code of ethics was itself deficient in offering guidance in circumstances such as arose in the case, the Court below held that the tribunal was not right in finding the appellant guilty as charged.

[63.] The main criticisms raised by counsel for the tribunal against the conclusion of the Court of Appeal can be summarised as follows:

- (1) The Court of Appeal failed to take cognisance of the fact that count 1(b) on the charge sheet alleged that the respondent failed to transfer the patient to a bigger centre where there would be no inhibition that would operate to the patient's advantage.
- (2) The options suggested by the tribunal can be deduced from rule 18 of the Rules of Professional Conduct upon a proper construction of that rule read together with rule 5. The Court of Appeal did not take due regard of these rules.
- (3) The constitutional provisions and authority relied on by that court are irrelevant.

Learned counsel for the respondent defended the Court below against these criticisms, supporting the opinion of that Court.

[64.] The opinion of the Court of Appeal that the tribunal jettisoned the charge of failure to transfuse blood to the patient and substituted it with one that the respondent ought to have terminated his contract with the patient or transferred the patient emanated from the concluding part of the tribunal's decision which was not in the exact terms of the charge. Particular (b) of the first count had alleged failure to transfer the patient to a bigger centre.¹ The concluding part of the tribunal's decision was that he held onto the patient. Having regard to the tribunal's earlier finding that the respondent failed to give other doctors and other health institutions an opportunity to obtain the patient's consent and administer the correct treatment, it cannot rightly be said that the tribunal substituted a new charge. To that extent the Court below was in error. However, no miscarriage of justice has been occasioned by this error, since the Court below proceeded to hold that the rules did not specify any such options as were found by the tribunal. That view has been challenged by counsel for the tribunal in this appeal.

[65.] He argued that rule 18 and rule 5 of the Rules of Professional Conduct form the basis of the tribunal's view as to what the respondent ought to have done in the circumstances that arose. Rule 18, as quoted in the appellant's brief, is as follows:

If the patient insists upon an unjust or immoral course in the course of treatment, or if he deliberately disregards an agreement, or obligation as to fees or expenses, the doctor may be warranted in withdrawing on due notice to the patient, allowing him time to employ another doctor. Other instances as they arise may justify withdrawal. Upon withdrawal from a case after a fee has been paid, the doctor should refund such part of the fee as has not been clearly earned.

Rule 5 as quoted in the appellants' brief provides, *inter alia*, that:

[A] doctor owes to his patient complete loyalty and all resources of his science. Whenever an examination or treatment is beyond his capacity, he should summon another doctor who has the necessary ability.

[66.] I would not have considered it needful to consider these rules in view of the opinion I have expressed that a charge of infamous conduct need not be tied to rules of conduct only. However, the tribunal had not relied on any other standard for judging the conduct of the respondent apart from the rules. It thus becomes necessary to inquire, as the Court below did, whether such a rule existed.

[67.] I am able to say that the Court of Appeal was right in the view it held that the two options which the tribunal stated in its decisions as open to the respondent were not expressly stated in the Rules of Professional Conduct, contrary to the tribunal's emphatic assertion that:

When therefore he (ie the practitioner) is faced with a dilemma arising from the refusal to grant informed consent our code of ethics prescribe that a doctor faced with such a dilemma has 2 options; (a) he can terminate the contract or (b) refer him or her to another doctor or health institution where necessary measures for preservation of life may be taken (*italics supplied*).

[68.] Neither rule 18 nor rule 5, nor both read together, justified the above assertion. I give two reasons. In the first place, rather than make it mandatory that the practitioner must withdraw his services, rule 18 merely stated that the practitioner may be warranted' to withdraw in the circumstances stated in the rule. The words may be warranted' I understand to mean may be justified'. Where the law or a rule is merely permissive or merely provides a justification for doing an act, what it permits cannot be regarded as a matter of obligation. There is a difference between a matter of obligation and a matter of liberty to do something. When the case of the tribunal is that a section breach by the practitioner of a duty imposed by the rules amounts to serious misconduct or infamous conduct, it must be clearly shown that such duty exists under the rules in clear language. It is an acceptable principle of interpretation that: Where there is an enactment which may entail penal consequences, you ought not to do violence to the language in order to bring people within it by express language.' (See *Rumball v Schmidt* (1882) 8 QBD 603, 608, cited in *Craies on Statute Law* (7th Ed) p 532.) If the respondent was to incur a penalty on the grounds that he had been guilty of infamous conduct by reason of a breach of the rules of conduct, it must be shown that those rules expressly prohibited what he did.

[69.] In the second place, for the occasion to exercise the liberty to withdraw from treating the patient to arise, the patient, in terms of rules 18, must have insisted upon an unjust or immoral course'. Whatever the law permits cannot be described as an unjust or immoral course'. The liberty which the law permits a competent adult to determine what would be done with or to his own body, when exercised by the competent adult, cannot be regarded as an unjust and immoral course. Rule 18 provides that Other instance as they arise may justify withdrawal'. That leaves the judgment primarily to the practitioner. If he made an error of judgment, that cannot be regarded as infamous conduct.

[70.] Rule 5 does not enjoin the practitioner to refer a patient who has refused medical treatment for religious reasons to another doctor or health institutions. The situation envisaged in rule 5 is one in which an examination or treatment is beyond that

practitioner's capacity. Where a patient refuses medical treatment for religious reasons, the professional capacity of the practitioner is not called into question by that fact alone.

[71.] In these circumstances, it is clear that the Court of Appeal was right when it concluded that the measure which the tribunal held the respondent should have adopted had not been part of the rules or code of conduct. It is evident that the Rules of Professional Conduct which the tribunal appeared to have relied heavily on did not offer much guidance in answering the question which the tribunal considered central to the case, namely: what course of action should a practitioner who has been denied informed consent to carry out a medical life-saving measure take?

Religious objection to medical treatment: limit of practitioner's responsibility

[72.] The scope and limit of the duty of a practitioner faced with a patient's refusal to give informed consent to life-saving medical treatment cannot be considered in isolation of the right of the patient. Although, there is a dearth of local authorities in this area of our law, there are ample provisions of our Constitution which show the basis on which the Court should proceed in these matters. It is expedient at the outset to recognise that a consideration of a religious objection to medical treatment involves a balancing of several interests, namely: the constitutionally protected right of the individual, state interest in public health, safety and welfare of society; and, the interest of the medical profession in preserving the integrity of medical ethics and, thereby, its own collective reputation. To give undue weight to one of these other interests over the rights of the competent adult patient may constitute a threat to liberty of the individual, unless legally recognised circumstances justify that weight should be ascribed to one over the others. Where, for instance, the health and safety of society is under threat, for instance in an epidemic, public health and safety may be given a higher weight than the individual's human rights. Where, however, the direct consequence of a decision not to submit to medical treatment is limited to the competent adult patient alone, no injustice can be occasioned in giving individual right primacy. In my judgment, any rule of ethics or professional conduct that ignores the need to balance these interests or that gives undue weight to any of them without regard to individual circumstances will be out of touch with reality and may lead to unjust consequences. This, in my understanding, was what Nzeako, JCA, tried to emphasise when she stated thus:

Everything put together, it does appear that the code of ethics which requires a medical practitioner to always take measures that will lead to preservation of life' failed to pin down on the conflict between the right of a patient to decide on what medical measures to agree to and the doctor's code of ethics.

[73.] The patient's constitutional right to object to medical treatment or, particularly, as in this case, to blood transfusion on religious grounds is founded on fundamental rights protected by the 1979 Constitution as follows: (i) right to privacy: section 34; (ii) right to freedom of thought, conscience and religion: section 35. All these are preserved in section 37 and 38 of the 1999 Constitution respectively. The right to privacy implies a right to protect one's thought, conscience or religious belief and practice from coercive and unjustified intrusion; and, one's body from unauthorised invasion. The right to

freedom of thought, conscience or religion implies a right not to be prevented, without lawful justification, from choosing the course of one's life, fashioned on what one believes in, and a right not to be coerced into acting contrary to religious belief. The limits of these freedoms, as in all cases, are where they impinge on the rights of others or where they put the welfare of society or public health in jeopardy. The sum total of the rights of privacy and of freedom of thought, conscience or religion which an individual has, put in a nutshell, is that an individual should be left alone to choose a course for his life, unless a clear and compelling overriding state interest justifies the contrary. The law's role is to ensure the fullness or liberty when there is no danger to public interest. Ensuring liberty of conscience and freedom of religion is an important component of that fullness. The courts are the institution society has agreed to invest with the responsibility of balancing conflicting interests in a way as to ensure the fullness of liberty without destroying the existence and stability of society itself. It will be asking too much of a medical practitioner to expect him to assume this awesome responsibility in the privacy of his clinic or surgery, unaided by materials that are available to the courts or, even, by his training. This is why, if a decision to override the decision of an adult competent patient not to submit to blood transfusion or medical treatment on religious grounds is to be taken on the grounds of public interest or recognised interest of others, such as dependent minor children, it is to be taken by the courts.

[74.] It is to the credit of the tribunal in this case that it acknowledged the right of the individual to hold his religious belief and that it also accepted that a practitioner should respect the religious beliefs of others. Its decision in the case, however, progressed into error when it deviated from the correct path into ignoring the concomitants of the right of the patient to reject medical treatment or blood transfusion on religious grounds, and concluded that the respondent was guilty of infamous conduct for holding onto the patient knowing fully well that the correct treatment cannot be given in the face of failure to obtain consent'.

[75.] Since the patient's relationship with the practitioner is based on consensus, it follows that the choice of an adult patient with a sound mind to refuse informed consent to medical treatment, barring state intervention through judicial process, leaves the practitioner helpless to impose a treatment on the patient. That helplessness presents him with choices. He could terminate the contract, and, I would say, callously, force the patient out of his clinic or hospital; he could continue to give him refuge in his hospital and withdraw any form to treatment; he could do the best he could to postpone or ameliorate the consequences of the patient's choice. To a large extent the practitioner should be the judge of the choice that may be better in the circumstances. The choices become a question of personal attitude rather than one of professional ethics. Indeed, in one case it has been said that the prevailing medical ethical practice does not, without exception, demand that all efforts towards life prolongation be made in all circumstances, but seems to recognise that the dying are more often in need of comfort than of treatment. (See Superintendent of Belckerton State School v Sackewicz noted in 93 ALR 3d 75.) That the patient's consent is paramount has been determined in several cases in the United State of America where this area of law has received considerable judicial attention. If a competent adult patient exercising his right to reject life-saving treatment on religious grounds thereby chooses a path that may ultimately lead to his death, in the

absence of judicial intervention overriding the patient's decision, what meaningful option is the practitioner left with, other, perhaps, than to give the patient comfort?

[76.] In several cases the courts have refused to override the patient's decision; in others, they have found ways round the problem of the paramountcy of the patient's consent. What is important is that in no case has the decision to override the patient's decision been left with the medical practitioner or the hospital. Several of these cases have been noted in 93 ALR 3d 67-85. In *re Yetter* (1973) 62 Pa D & C 2d 619, upon evidence that the patient was a mature, competent adult, had no children, and had not sought medical attention and then attempted to restrict it, the Court said that the constitutional right of privacy includes the right of a competent, mature adult to refuse treatment that may prolong his or her life even though that refusal may seem unwise, foolish or ridiculous to others. (See 93 ALR 3d 77.) In *re Osborne* (1972, Dist Col App) 294 A 2d 372, the Court affirmed the lower court's order refusing to appoint a guardian to give consent for the administration of a blood transfusion to a patient who had refused it on religious grounds, and whom the physician feared would die without blood, upon evidence that the patient had validly and knowingly chosen this course, and upon the lower court's finding that there was no compelling state interest which justified overriding the patient's decision to refuse blood transfusions.

[77.] The principle of these cases is to some extent reflected in the opinions in *Sidway v Board of Governor Bethlehem Royal Hospital* (supra) where at page 645 (of [1985] 1 All ER) Lord Scarman, albeit in a slightly different context, said:

[T]he courts should not allow medical opinion of what is best for the patient to over-ride the patient's right to decide for himself whether he will submit to the treatment offered him.

And Lord Templeman, at 666 said:

The patient is free to decide whether or not to submit to treatment recommended by the doctor ... If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject the advice for reasons which are rational or irrational or for no reason.

[78.] There is no duty, contrary to what was suggested in the particulars of the first count, on the respondent to transfer the patient to another hospital merely because she had refused to submit herself to blood transfusion by reason of her religious belief. An inadequate consideration of the law as it now stands has no doubt misled the tribunal into assuming that a 'bigger centre' would have been free from the constraints of legal inhibition so as to be able to brush aside the patient's right and override her decision. As rightly held by the Court below, the respondent was not influenced by his personal belief in failing to effect blood transfusion to the patient. His only inhibition, it would appear, was the legal inhibition that would have operated on any other medical practitioner, or hospital, as it did him and Dr Okafor of Kenayo Hospital before him. The charge is misconceived in implying that a 'bigger centre' would have been free from the legal inhibition which operated on the respondent in failing to over-ride the patient's decision. Even bigger hospitals have to respect the patient's decision and choice.

[79.] There is no doubt that the tribunal came to a wrong conclusion by its misplaced emphasis on the respondent's belief rather than the patient's belief. It ignored the respondent's evidence that notwithstanding his belief he had transfused blood to consenting patients before. It misinterpreted the respondent's rightful regard for the patient's wishes as collusion. It failed to give adequate regard to the conduct of the respondent in the light of accepted principles of law enjoining medical practitioners to respect a competent adult patient's refusal of medical treatment, including blood transfusion, for religious reasons. It ignored the choice made by the patient and her husband of where she would be treated and the evidence that the patient and her husband rejected an offer of discharge. All these considerations were implicit in the judgment of the Court of Appeal.

[80.] A charge of infamous conduct must be of a serious infraction of acceptable standards of behaviour or ethics of the profession. It connotes conduct so disreputable and morally reprehensible as to bring the profession into disrepute if condoned or left unpenalised. Although the medical profession is the primary judge of what is infamous conduct, it cannot do so without paying attention to what the law permits, either of the patient or of the practitioner. From the facts as found by the Court of Appeal it is difficult to see anything that is infamous in the conduct of the respondent.

[81.] If I may proffer an opinion, gratuitous though it may be, it is that the medical profession and the public will profit more if more attention is paid to a consideration of what legal remedies may be available to make objecting competent adult patients, in appropriate cases, submit to life-saving medical treatment. If such remedies as there are are found inadequate, the solution is to be found in making the legal system fashion adequate remedies. The solution, in my opinion, is not in, unwittingly, making a hapless practitioner a scapegoat of the consequence of whatever deficiency there may be in the remedy provided by our laws; nor is it in making the medical practitioner pay for the failure of concerned relations of the patient to seek legal advice and such remedies as the law might have offered at the time when such might have made a difference. Had such remedies been sought, the responsibility of deciding whether or not the decision of the patient should be overridden would have shifted to the courts, which are the proper forum for such decision. Besides, granted that the medical profession may offer guidance to its members at any time, it is unjust to find a practitioner guilty of infamous conduct in an issue on which there have been neither rules nor can be regarded as standard practice, or for conduct which is not inherently infamous.

[82.] Be that as it may, for the reasons that I have stated, I feel no hesitation in holding that the Court of Appeal came to a correct decision on the merits of the case. In the result I dismiss the appeal with N10 000 costs to the respondent.