

SUPREME COURT OF NIGERIA
2ND MARCH, 2001. SC. 213/1999.
CORAM:- S. M. A. BELGORE, S. U. ONU, O. ACHIKE,
S. O. UWAIFO, E. O. AYoola, JJSC.

MEDICAL AND DENTAL PRACTITIONERS APPELLANT
DISCIPLINARY TRIBUNAL

AND

DR. JOHN EMEWULU NICHOLAS OKONKWO RESPONDENT

ADMINISTRATIVE LAW - *Conduct of medical practitioner - Refusal of an adult patient to give informed consent - Leaves the practitioner helpless to impose medical treatment - Barring intervention from the courts - Options open to the practitioner in such cases.*

ADMINISTRATIVE LAW - *Professional conduct - Rules of - Interpretation - Doctor faced with patient's refusal to grant informed consent for medical treatment - The rules did not create any mandatory obligation - That the doctor must follow.*

ADMINISTRATIVE LAW - *Tribunals - A charge before a disciplinary committee - Should not be construed - To charge an offence not expressly mentioned.*

ADMINISTRATIVE LAW - *Tribunals - Charges - Once particulars are given - Of acts and omission complained of - Reference to the particular breaches of rule - Is an optional matter of details.*

ADMINISTRATIVE LAW - *Tribunals - Medical Practitioners Disciplinary Tribunal - Infamous conduct - Cannot be determined without paying attention - To what the law permits of the doctor or his patient.*

ADMINISTRATIVE LAW - *Tribunals - Medical Practitioners Disciplinary Tribunal - There is no duty on a doctor - To transfer a patent to a*

bigger or another hospital - If the patient objects to life saving treatment.

APPEALS - *Grounds of Appeal - Nature of - How to determine whether a ground - Is one of law or of fact.*

APPEALS - *Grounds of Appeal - Procedure to be followed - In resolving an objection - On the issue of raising a question of mixed law and fact - Without the requisite leave.*

APPEALS - *Issues - Error - Though the lower court misunderstood the issues - As tried by the tribunal - No miscarriage of justice was occasioned.*

APPEALS - *Jurisdiction - Tribunals - Medical Practitioners Disciplinary Tribunal - As the count complained of did not imply any criminal offence - The court below wrongly denied jurisdiction.*

APPEALS - *Tribunal - Its decision was not a nullity - As held by lower court - Because the defect in the charge was a mere irregularity - That did not occasion miscarriage of justice.*

CONSTITUTIONAL LAW - *Fundamental human rights - Religious objection to medical treatment - Any rule of ethics or professional conduct - That fails to balance public interest with the individual's right - May lead to unjust consequences.*

CONSTITUTIONAL LAW - *Fundamental human Rights - Religious objection to medical treatment - It is the duty of the court - To determine when to override this right - And not that of a medical doctor.*

FUNDAMENTAL HUMAN RIGHTS - *Limitation - Religious objection to medical treatment - Is a constitutionally protected right - But it will be limited by compelling overriding state interest.*

JURISDICTION - Tribunal - Medical practitioners disciplinary tribunals - Has no jurisdiction - To try offences covered by the criminal code.

FACTS

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. The patient had a severe ailment and transfusion was recommended by the medical practitioner of the previous hospital where she was sent to. The practitioner discharged the patient consequent upon giving her a document which stated that the patient and her husband strongly refused blood transfusion. Upon her discharge from the previous hospital, she was taken to JENO hospital where they produced a card signed by the patient titled "*MEDICAL DIRECTIVE/ RELEASE*", another document signed by the patient's husband was also produced titled "*RELEASE FROM LIABILITY*." The combined effect of the documents is such that the patient should not be given blood transfusion but rather recommended the transfusion or otherwise of Ringer's lactate solution, glucose or other volume expanders not derived from blood. Again, the medical practitioners, hospital and nursing personnel were released from liability. The respondent (Dr. Okonkwo) proceeded to treat the patient without transfusing blood. However the patient died.

The respondent was charged before the Medical and Dental Practitioners Disciplinary Tribunal which found the respondent guilty and suspended him for a period of six months on each of the charges to run concurrently. On appeal by the respondent to the Court of Appeal all the issues were resolved substantially in his favour and it allowed the appeal and set aside the decision of the tribunal. The tribunal being dissatisfied appealed to the Supreme Court. The tribunal formulated six issues for determination which was narrowed down to three.

ISSUES FOR DETERMINATION

[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.

HELD (Unanimously dismissing the appeal per lead judgment of **AYOOLA JSC**)

Grounds of appeal - Nature of

1. 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 fact to be proved. It is not wise to attempt a list of instances in which a ground involves questions of law alone.

It suffices to say that there is now a growing list of authorities affording guide to the determination of the nature of a ground of appeal. The most often cited is Ogbechie v Ors v. Onochie & Ors [1986] Vol. 7 NSCC 443 [No1]. 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. (p. 760 A)

Grounds - Procedure to be followed - In resolving an objection

2. 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 objection 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 respondents' brief, which are all issues of law, the conclusion inescapable is that the preliminary objection is utterly disingenuous. (p. 761 A)

Jurisdiction - Tribunal

3. The function of the Medical and Dental Practitioners Investigating 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 courts established for trial of such offence.

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. (p. 763 G & 765 B)

Tribunals - Charge before disciplinary committee

4. 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. (p. 767 F)

Appeals - Jurisdiction - Tribunals

5. 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. (p.768 B)

Tribunals - Charges - Once particulars are given

6. At best, reference to particular breaches of rules of the charge is an optional matter of details 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.”

Furthermore, the law is clear that conviction on a charge 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. (p. 771 B)

Tribunal - Its decision was not a nullity

7. 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 determine 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 not 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. (p. 771 D)

Appeals - Issues - Error

8. 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. (p. 774 C)

Professional conduct - Rules of - Interpretation

9. 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 (i.e. the practitioner) is faced with a dilemma arising from the refusal to grant informed consent our Code of Ethics prescribed 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." Emphasis mine)

Neither Rule 18 nor Rule 5, nor both read together, justified the above assertion.

In the first place, rather than make it mandatory that the practitioner must withdraw his service, 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 serious 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 do violence to the language in order to bring people within it, but ought rather to take care that no one is brought within it who is not brought within it by express language."* (See Rumball v. Schmidt (1882) 8 QBD 603, 608: Cited in Craies on Statute Law (7th Edn) p. 532). If respondent was to incur a penalty on the ground 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. (p. 775 B)

Objection to treatment - Public interest and the individual's right

10. In these circumstances, it is clear that the Court of Appeal was right
 B when it concluded that the measures which the Tribunal held the respon-
 dent should have adopted had not been part of the rules or code of con-
 duct. It is evident that the Rules of Professional Conduct which the Tri-
 bunal appeared to have relied heavily on did not offer much guidance in
 C 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?
 (p. 776 G)

D Limitation to religious objection to medical treatment

11. 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
 E 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 prac-
 F tice 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 one's religious
 G belief. The limits of these freedoms, as in all cases, are where they im-
 ping 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
 H 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. (p. 777 H)

Religious objection to medical treatment - Duty of the court

12. 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. (p. 778 F)

Refusal to give informed consent - Leaves the practitioner helpless

13. 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 of 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 States 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 part that may ultimately lead to his death, in the absence of judicial inter-

vention overriding the patient's decision, what meaningful option is the practitioner left with, other, perhaps, than to give the patient comfort? (p. 779 B)

B *No duty on a doctor - To transfer a patient to a bigger hospital*

14. 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 Kanayo Hospital before him. The charge (sic Tribunal) 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. (p. 780 H)

F *Disciplinary Tribunal - Infamous conduct - How determined*

15. 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. (p. 781 H)

NOTABLE POINTS OF INTEREST

H AYOOLA JSC

1. Charge - Should not be subject to speculation

It is not part of our system of criminal justice that the contents of a charge should be subject of speculation and inference. The law is clear

beyond peradventure that the essential elements of the offence should be disclosed in the charge. (p. 767 D)

2. *Not every infraction of code of ethics amounts to infamous conduct*

The term infamous conduct is wide. It is futile, in the absence of statutory definition limiting its ambit to restrict its meaning within the confines of a code of ethics. 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 generally understood. (p. 769 C)

3. *How to make objecting patients submit to life-saving treatment*

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 decisions. 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 on an issue on which there has been neither rules nor what can be regarded as standard practice, or for a conduct which is not inherently infamous. (p. 782 B)

REPRESENTATION

G. A. Adetola-Kazeem Esq., (settled the brief) for the Appellant.

N. Odibe (with him P. A. Mrakpor, J.A. Etieyibo and I. E. Ogoruvwe) for
B the Respondent

CASES REFERRED TO

Didaway v. Board of Governor Bethlehem Royal Hospital (1985) 1 AC
871

C Malette v. Shulma 47 DLR (4th Edition) 18

Shanu & Anor v. Afribank (Nigeria) Ltd. (2000) 13 NWLR (Part 684)
392

Garba v. Ors v. University of Maiduguri (1986) 1 NSCC 245

D Law society v. Gilbert [The Times; Jan 12 2001]

Commissioner of police v. Ohoyen (1964) Vol. 7 NSCC 217

R v. Iyoma (1962) Vol. 2 NSCC 295

Rumball v. Schmidt (1882) 8 QBD 603, 608

E J.B. Ogbechie & Ors. v. Gabriel Onochie & Ors. (1986) 3 SC.54

Chidiak v. Laguda (1964) NSCC 100

Bello & 13 Ors. v. A-G, Oyo State (1985) 5 NWLR (Part 45)

LEAD JUDGMENT BY AYoola.JSC

F 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; or, terminate his medical con-
G tract; or, refer the patient to another health institution or another medical
doctor.

The facts which led to this question are largely undisputed and
can be briefly stated. Mrs. Martha Okorie (the patient") and her husband
H 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."

They believe that the prohibition was passed to the "Gentiles", that is, non-Jews in Acts 15:29 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.

Mrs. Okorie, a 29-year old woman, having had a delivery at a maternity on 29th July, 1991 was admitted as a patient at Kanayo Specialist Hospital for a period of 9 days from 8th August, to 17th August, 1991. She had complained of difficulty in walking and severe pain in the pubic area. At Kanayo 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 of 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"

Upon her discharge from Kanayo Hospital she was taken to JENO hospital by her husband on 17th 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 or 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 year. I direct that I be given no blood transfusions. I accept any added risk this may bring . I release doctors, anesthesiologists, 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 either witness below to see that my decision is held.

Sgd Martha Okorie Date: 23/2/91

Witness Sgn. LOVEDAY C. OKORIE HUSBAND

Witness Sgn. UKWUOMA C. A.- UNCLE

Printed in Nigeria.”

In another document signed by the patient’s husband dated 17th 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 case of Mrs. MARTHA OKORIE (MY WIFE) You are hereby notified and instructed that i do not wish any transfusion of whole blood , blood plaoma, 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 opinion that blood transfusion is necessary perhaps 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 loatate 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 for 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,

Sgd. Loveday Okorie (Husband)
Patient, Parent or Guardian."

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

B

The Charge

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.

C

The allegations in the first count were that:

"(a) although it was clear from the referral letter from Kanayo 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

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(b) although 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;"

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:

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"(a) it was clear that only blood transfusion could possibly save the patient's life, but

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(b) because 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

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 I”) 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 the 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.”

Cross-examined, he said that had the patient consented to 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 blood transfusion for his failure to apply blood transfusion. He said that he 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 blood transfusion even after being warned by the defendant of the possible consequence of their decision.

The Judgment of the Tribunal

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?

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 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.”

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 own 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 ground 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.”

The Tribunal concluded its judgment by holding that the respondent was not criticized for holding “this belief” or for respecting the religious belief of others, but for holding on to the patient knowing full well that the

correct treatment cannot 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 charge” to run concurrently.

B The appeal to the court of Appeal

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.

C
D The Court of Appeal (Oguntade, Aderemi and Nzeako JJ.C.A) held that the charge as laid in the first count connoted that the inaction on the part of the respondent amounting to negligence led to the death of the patient and was an allegation of a criminal offence. In the result it held that the
E 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
F the count.

In regard to the second issue the court below held that the failure to charge the respondent with 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
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H 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.

Although on the basis of the determination of the second issue the court below set aside the decision in its entirety, it took a wise and

helpful course in considering the third 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 (i) 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 criticized the code of ethics for failing "to pin down on the conflict between the right of a patient to decide on what medical measure to agree to and the doctor's code of ethics".

To buttress its conclusions it cited the Canadian case of Malette v. Shulma 47 DLR (4th Edition) 18 and the English case of Didaway v. Board of Governor Bethlehem Royal Hospital [1985] 1 AC 871.

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

This Appeal

Preliminary Objection

The Tribunal raised 8 grounds of appeal by its Notice of Appeal dated 12th July, 1999 From these grounds of appeal 6 issues for determination were formulated by counsel for the Tribunal. These are contained in the appellant's brief of argument filed on 29th December, 1999. The respondent's counsel, for his part, formulated five for determination distilled, also from all the eight grounds of appeal. They are contained in the respondent's brief of argument filed on 11th February, 2000.

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 14th November, 2000 by his counsel objected to the fifth,

seventh and eight grounds of appeal on the ground that they did not involve questions of law alone and that requisite leave to appeal was not obtained. Ground 6 was objected to on the ground that it was vague and its purport was unclear.

B Without stating the particulars the grounds of appeal to which objections has 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.*

C “(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 Respondent is simply that the Tribunal*

D *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 Count 19 (a) and Count 2, charging him with making no plans to transfuse blood and not transfusing blood. For*
E *it was the Tribunal that stated as follows:*

‘We criticized the defendant doctor not for holding this religious belief But for holding unto the patient knowing fully (sic) well that the correct treatment cannot be given in the face of failure to obtain consent’

F *The statement by 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, when ‘he was faced with a dilemma arising from the refusal to grant informed*
G *consent,’ and that he held on to the patient knowing full (sic) well that the correct treatment cannot be given in the face of failure to obtain consent.”*

H *“(7) The Court of Appeal failed to appreciate the submission in the Respondent’ 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 of the Tribunal which had indeed found that the Appellant did not transfer (sic) blood because of the refusal of the 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-a'-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?"

In regards 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 know 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-a-vis the professional duty of the medical practitioner in the face of studied refusal of a patient / or his next-of kin as case may be"

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

(a) where the ground of appeal involves questions of law (from) decisions in any civil or criminal proceeding 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 fact to be proved. It is not wise to attempt a list of instances in which a ground involves questions of law alone.

It suffices to say that there is now a growing list of authorities affording guide to the determination of the nature of a ground of appeal. The most often cited is Ogbechie v Ors v. Onochie & Ors [1986] Vol. 7 NSCC 443 [No1]. 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 (part 684) 392. In that case this court held thus:

"Where the ground of appeal complains that the tribunal has failed to fulfil 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."

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 determina-

tion 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.

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 objection 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 respondents' brief, which are all issues of law, the conclusion inescapable is that the preliminary objection is utterly disingenuous.

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.

Although six issues for determination were formulated by counsel for the Tribunal and five issues by the counsel for 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?

The Court below held that the Tribunal had no jurisdiction to try the offence charged in count I 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 amounting to negligence 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 section 304 (5), or, an offence under section 343 (1)(e).

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 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).”

Relying on Denloye v Medical and Dental Practitioners Disciplinary Committee [1968] 1 ALL NLR 306 the court below held 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 sections 82 and 89 of the Criminal Code were charged in the remaining four count. 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 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 intentment of the Act. Ademola, CJN, delivering the judgment of the court

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.” [p 264] B

At p. 265 he said:

“In effect where the unprofessional conduct of the practitioner amounts to a crime, it is a 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.” (Emphasis mine) C

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 allegation 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(!) and (2), and section 33(1) and (4) of the 1979 Constitution. D E

Constitutional provisions apart, it is clear that the Tribunal with which the present case is concerned is set up to try special 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 Practitioner Investigating 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** F G H

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 courts established for 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 complication may arise.

The recent English case of Law Society v. Gilbert [The Times Jan 12, 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 Society then brought a second set of disciplinary proceedings based on that convictions. 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, C.J., 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 of any criminal proceeding before commencing the first set of disciplinary proceedings. However, such a course had real disadvantages. The Law Society would have to defer for maybe a substantial period the bringing of disciplinary proceedings. That could have meant that the public was put to risk."

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

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 one charged 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 count charges the accused of negligence. What is the degree of negligence can be read from the particulars and that is what determines 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: expressly?) stated that the omission was the cause of the death of the patient, the inference can be drawn that 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 - a charge of negligence influenced by the Appellant's religious faith re-

sulting 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,” (Emphasis mine)

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).

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.”

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 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 basis of liability would have been required.

The court below seemed to have realised that the section does not by itself create an offence when it tried to invoke 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 of this” i.e. section 305 A.

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 need to charge a specific offence.

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 misdemeanour and is liable to imprisonment for one year.”

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 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.

Counsel for the respondent submitted that charged in the first count were offences 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 consonance 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.

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?

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 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.

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 Q B 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

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.”

Relying thereon he submitted that the provisions of section 16(1)(a) of the Act and of Rules 9 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.

The term infamous conduct is wide. It is futile, in the absence of 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 E R 686, Lord Guest, at p 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.”

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 generally understood. In the case of Allinson “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 part Meehan, 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.

B (See 33 The Digest No 2369 at page 297).

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 penalty that can be imposed consequent on conviction of a registered person, provided for 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 word ‘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 charge the law but to replace outdated phraseology.”

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.”

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, 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 of the charge is an optional matter of details 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.”**

Furthermore, the law is clear that conviction on a charge 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 determine 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 not 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?

The first arm of first 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 proceed 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 “Code of Ethics” of the medical profession. Its statement of those two options have been set out earlier in this judgment.

The Tribunal proceeded to make findings as follows:

- [i] *The respondent “colluded” with the patient to deny life on religious grounds and such is incompatible 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 ground of religion as such is unethical to the medical profession*
- [iv] *The respondent is not criticized for holding the material religious belief or for respecting such belief or other “but for holding on to the patient knowing fully well that the correct treatment cannot be given in the face of failure to obtain consent.”*

I may well add that in passing sentence the Tribunal recognised “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.”

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 fail-

ure 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, when 'he was faced with a dilemma arising from the refusal to grant informed consent', and that he held on to the patient knowing fully well that the correct treatment cannot be given on the failure to obtain consent.' B

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 "if 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 e.g. in the case of surgery or blood transfusion as in the present case." It relied for the view on the Canadian case of Malette v Shulman 47 DLR [4th Edition] 18 and the English case of Sidaway v Board of Governor Bethlehem Royal Hospital [1985] A.C 871; [1985] All E R 643. C D

The Court of Appeal acknowledged that the Tribunal limited itself "to proposing optional measure 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. E F

The main criticisms raised by counsel for the Tribunal against the conclusions of the Court of Appeal can be summarised as follows: G
(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.* H

(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.

B 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. C Particulars (b) of the first count had alleged failure to transfer the patient to a bigger centre. The concluding part of the Tribunal's decision was that he held on to the patient. **Having regard to the Tribunal's earlier finding that the respondent failed to give other doctors and other D 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 E 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.

F 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 have done in the circumstances that arose. Rule 18, as quoted in the appellant's brief, is as follows:

G *"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 H 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.” 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 needs not be tied to rules of conduct only. However, the Tribunal had not relied B on any other standard of judging the conduct of the respondent apart from the rules. It thus becomes necessary to inquire, as the court below did, whether such rule existed.

I am able to say that the Court of Appeal was right in the C 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 (i.e. the practitioner) is faced with a di- D
lemma arising from the refusal to grant informed consent our Code of Ethics prescribed that a doctor faced with such a dilemma has 2 op-
tions;* .

(a) he can terminate the contract or E

(b) refer him or her to another doctor or health institution where necessary measures for preservation of life may be taken.” Emphasis mine)

Neither Rule 18 nor Rule 5, nor both read together, justified the F above assertion. I give two reasons.

In the first place, rather than make it mandatory that the practitioner must withdraw his service, Rule 18 merely stated that the practitioner “may be warranted” to withdraw in the circum- G
stances 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 H
difference between a matter of obligation and a matter of liberty to do something. When the case of the Tribunal is that a serious 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 do violence to the language in order to bring people within it, but ought rather to take care that no one is brought within it who is not brought within it by express language.” (See Rumball v. Schmidt (1882) 8 QBD 603, 608: Cited in Craies on Statute Law (7th Edn) p. 532). If respondent was to incur a penalty on the ground 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.

In the second place, for the occasion to exercise the liberty to withdraw from treating the patient to arise, the patient, in terms of Rule 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 provided that “Other instances 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.

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.

In these circumstances, it is clear that the Court of Appeal was right when it concluded that the measures 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

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 interest over the right 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 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."

The patient's constitutional right to object to medical treat-

ment 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.

B 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.

C 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 one's religious belief. The limits of these freedoms, as in all cases, are

D 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

E be left alone to choose a course for his life, unless a clear and compelling overriding state interest justifies the contrary. Law's role is to ensure the fullness of liberty when there is no danger to public interest. Ensuring liberty of conscience and freedom of religion is an important

F 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

G 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

H 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.

It is to the credit of the Tribunal in this case that it acknowl-

edged the right of the individual to hold his religious belief and that it also accepted that a practitioner should respect the religious belief 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.”

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 of 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 States 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 part 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?

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) 63 Pa D & C2d 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 one's 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 A2d 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.

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

"the 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 p 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."

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 Kanayo Hospital before him. The charge (*sic Tribunal*) 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.

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.

A charge of infamous conduct must be of a serious infraction of acceptable standard 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.

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 decisions. 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 on an issue on which there has been neither rules nor what can be regarded as standard practice, or for a conduct which is not inherently infamous.

Be that as it may, for reason 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.

H BELGORE JSC

I read in advance the judgment of my learned brother Ayoola JSC and I am in full agreement with him that this appeal has no merit. I also dismiss the appeal with the consequential order as to costs.

ONUJSC

Having had the opportunity of reading before now the comprehensive judgment of my learned brother Ayoola, JSC just delivered, I am in agreement with him that the Court of Appeal (hereinafter referred to B shortly as the court below) came to a correct decision on the merits of the case that the appeal be dismissed.

Of all the issues submitted as arising by both counsel for the parties, see Appellant's issues set out hereunder, two stand out for treatment and consideration. C

The first asks whether it is legally possible to have charged the Respondent medical practitioner with a criminal offence by implication

The Second issue is whether the Tribunal was wrong to have found the respondent guilty on counts 1(a) and 2 when it had found as a D fact that the Respondent could not have transfused blood in the absence of the patient's consent.

In order to fully appraise the first issue and its purport, it is pertinent firstly, to examine allegations contained in Count 1, which read E as follows:

"That you Dr. John Emewulu Nicholas Okonkwo, being a registered medical practitioner between the 17th and 22nd day of August, 1991 at JENO HOSPITAL, Enugu of which you were the Proprietor and F Medical Director, did attend to one Mrs. Martha Okorie in a negligent manner in that:

(a) although it was clear from the referral letter from Kanayo Specialist Hospital, Onitsha where the patient had been previously admitted that the patient was severely anaemic, which said diagnose (sic) G 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) although you claimed inhibition for your failure to apply an H obviously correct treatment to the patient, you failed to transfer the patient to a bigger centre where such inhibition would not operate to the patients's disadvantage;

(c) *AND that by the said act, you have conducted yourself infamously in a professional respect contrary to Medical Ethics and punishable under Section 16 of the Medical and Dental Practitioners Act.*”

I take the view from the purport of the above charge that the count B (count 1) constitutes crimes under the Criminal Code (Cap. 77) Laws of the Federation of Nigeria, 1990.

But first, the Appellant’s issues for determination, viz:

ISSUE NO. 1

C *Whether it is legally possible to have charge the Respondent Medical practitioner with a criminal offence by implication.*

ISSUE NO. 2

D *Whether the negligent action or inaction of the Respondent Medical practitioner in the course of his professional duty in consequence of which the patient died necessarily amounted to criminal negligence triable under Section 303 and 343 (1)(e) of the Criminal Code, Cap. 77, Laws of the Federation of Nigeria, in a court with appropriate jurisdiction, and not an issue of professional negligence triable as a breach of Professional Ethics by Medical and Dental Practitioners Disciplinary Tribunal pursuant to Sub-section 16(1)(a) of the Medical and Dental Practitioners Acts, Cap.341, Laws of the Federation of Nigeria, 1990.*

ISSUE NO.3

F This overlaps Grounds 3 and 4 of the Grounds of appeal which complain that the court below erred in law by failing to draw the correct analogy between Count 1 in DENLOYE V. MEDICAL PRACTITIONERS COMMITTEE (1968) 1 All NLR 306 at 311-312 which was upheld by the Supreme Court as a valid charge e.t.c., and the court below erred in law to have held after citing Section 303 of the Criminal Code, Cap.77 LFN, that -

H *“These provisions have far- reaching application. When placed against the charge with its particulars it does in my view embody the type of situation complained of in Count 1. Section 305 (A) of the Code provides that any person guilty of this offence shall be liable, on conviction to a fine of N100, or to both such fine and imprisonment.....”*Vis a vis Section 305A and 301 of the Crimi-

nal Code, Cap.77 LFN, 1990

ISSUE NO. 4

The poser in issue 4 which is based on Ground 5 is whether the court below was correct to have held that the charge against the Respondent Medical Practitioner was invalid, because it did not state the particular Code of Ethics that was alleged to have been breached. B

ISSUE NO.5

Issue 5 which is concomitant with Grounds 6 and 7 asks whether the court below was correct to have held that the Tribunal had by its conclusion replaced the original charge with a new one, and that the question whether the Respondent Medical Practitioner made any plan originally to transfuse the deceased with blood, had therefore become irrelevant. D

ISSUE NO. 6

The question issue No. 6 (based on Ground 8) asks is : was the correct question, as held by the court below in this case, whether a medical practitioner who had been denied informed consent with respect to a particular treatment ought to proceed to administer that medical measure, or as to what steps a medical practitioner who had been so denied informed consent to administer a medical measure which is the only option available to save the patient's life, take with regard to that patient? F

The Respondent has for his part , submitted five similarly couched issues for our determination.

Before I commence my consideration of these issues together, it is pertinent to advert to the following preliminary issues viz that at the hearing of this appeal on 7th December, the Appellant was not represented and this led to the questioning of the Registrar of court who stated that Hearing Notice was served on the Appellant on 13th June, 2000. However, before taking the Appellant's Brief in this Court on 21st December, 1999 as argued following the delivery of the judgment of the court below on 14th June, 1999 in favour of the Appellant, herein Respondent, (reversing the conviction and sentence by the Tribunal) Mr. G H

Odibe, learned counsel for the Appellant, raised a Preliminary Objection brought pursuant to Order 2 Rule 9(1) of the Supreme Court Rules, as amended, that as Grounds 5, 6, 7 and 8 contained on pages 293, 294 and 295 of the Records should be struck out as they raise questions of fact, mixed law and fact. After ruling there and then that the point would be addressed in our final judgment, learned counsel stated that the Respondent filed his Reply Brief on 11/2/2000 after which he urged us to dismiss the appeal. The matter does not however end there.

It remains for me to consider Ground 8 which is contained at page 295 of the Record and attacks the decision of the court below as having misconceived the issue before it when it made certain pronouncements followed by particulars (a), (b) and (c) of the misconception alleged. As this Court had occasion to point out in J.B. Ogbechie & Ors. v. Gabriel Onochie & Ors. (1986) 3 SC.54 at pages 58-59:

“There is no doubt that it is always difficult to distinguish a ground of law from a ground of fact but what is required is to examine thoroughly the grounds of appeal in the case concerned to see whether the grounds reveal a misunderstanding by the lower tribunal of the law, or a misapplication of the law to the facts already proved or admitted, in which case it would be question of law. Where however the grounds are such that would reveal or are grounds that would question the evaluation of facts by the lower tribunal before the application of the law that would amount to a question of mixed law and fact. The issue of pure fact is easier to determine.”

See also the case of Chidiak v. Laguda (1964) NSCC 100 where this Court held per curiam:

“Ground 5 above is not a direction but finding of fact by trial Judge, as the other grounds alleging misdirection. A misdirection occurs where the trial Judge, sitting alone misconceives the issues or summarises the evidence inadequately or incorrectly or makes a mistake of law, but described as a misdirection”.

In the result I hold that Ground 8 herein is a ground of law and arguable and no leave is needed pursuant to Section 213 (2)(a) of 1979 Constitution (now Section 233 (2)(a) of the 1999 Constitution to argue it.

Once the Appellant was absent from court, we deemed its Brief as having been argued and so proceeded with hearing the appeal. Learned counsel for the Respondent having withdrawn his objection to Grounds 5 and 6, both of these became arguable.

Now, back to the issues.

On Issue No.1 which is based on Grounds 1-4, I agree with the Respondent's argument at paragraph 5.01 that where from the particulars set out therein, the alleged facts clearly contain elements of crimes or substances of facts amounting to or resembling facts that amount to various crimes and where the court says that the Respondent (Appellant in the court below) knew what should be done but made no plans or refused to do that necessary thing until death occurred; these allegations of knowledge from the onset, of the patient's condition and of what ought to be done, the consequences of not doing it and deliberate refusal to plan to do it as well as deliberate refusal to do it, amounts to:

(a) *negligence under Section 343(1)(e) of the Criminal Code;*

(b) *murder under Section 316 of the Criminal Code which defines the circumstances in which unlawful killing as defined in section 300 to 314 amounts to murder; and by Section 303, 306, 308 of the Criminal Code, the Respondent is deemed to have killed the deceased;*

(c) *or in the alternative by Section 303, 306, 308 and 317, manslaughter.*

Negligence as alleged and the circumstances expressed in the charge definitely amount to gross negligence, recklessness, criminal negligence of a very high degree involving wilful conscious acts-toying with life. As a matter of facts recklessness and negligence as alleged in this case are not entirely different terms, because recklessness really means aggravated negligence. See Bello & 13 Ors. v. Attorney-General, Oyo State (1985) 5 NWLR (Part 45) 828 - a case where a convicted armed robber whose further appeal from the High Court to the Court of Appeal on being dismissed, further appealed to the Supreme Court. Before his appeal was heard by this Court, he was hanged while in prison and this negligence gave rise to a case for compensation by dependents of the deceased since he was said to be their sustainer. In fact, the negligence

alleged in Count 1 and its particulars are of such a gross nature as to bring the charge within the purview of the regular courts as offences against Section 343(1)(e) and Section 303 of the Criminal Code, with their attendant provisions for punishment. See the cases of R. v. Bateman B (1925) 94 L.J. R. v. Akerele (1941) 7 WACA 56 and Kim v. The State (1992) 4 NWLR (part 233) 17 - cases which embody the principles applicable to the classification and distinction between ordinary and gross negligence. Even where the negligence is of a gross nature but not as high as that required for a charge of manslaughter, it will ground a conviction for an offence under Section 343(1)(e) of the Criminal Code. But C se the case of Udabkholkar v. R (1948) AC.221 where it was held that for negligence to be severe enough to ground a conviction under Section 222 of the Tanganyika Penal Code (equivalent of Section 343 (1)(e) of D Criminal Code) it must be higher than ordinary negligence but need not be as high as that required for a charge of manslaughter. The contention in the Appellant's Brief at page 7 paragraphs 4.1.2-4 that the court below suggests a criminal charge by implication and that it is a constitutional E impossibility are, in my view, entirely misconceived, as the court below was merely stating that upon examining the charge and its particulars, notwithstanding how they are couched, substance and elements of crimes are contained therein. The court is entitled to examine the charge in that F light, just as this Court did in Denloye v. Medical and Dental Practitioners Disciplinary Committee (supra). In that case a charge that had been laid before the Medical and Dental Practitioners Disciplinary Tribunal was adjudged bad for containing allegations of crimes. This Court in reaching that conclusion observed: "We are however satisfied that the substance G of the facts in each of Counts 2, 3, 4 and 5 is covered by various sections of the Criminal Code and charges could have been laid under the code."

This was precisely what the court below also did at page 267 line 16 to page 268 line 21 of the records when it stated:

H "In other words, the charge as laid connotes that the inaction on the part of the Appellant amounting to negligence led to the death of Martha Okorie."

The court below backed up the above quotation with another quotation

of Section 303 of the Criminal Code by stating:

“These provisions have far-reaching application. When placed against the charge with its particulars it does in my view, embody the type of situation complained of in Count 1.” See page 268, lines 3-6 and 19-21.

It was further argued in the court below and 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. In agreeing with the view, the court below went on to observe thus:

“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, when faced with a dilemma arising from the refusal to grant informed consent’, and that he held on to the patient knowing fully well that the correct treatment cannot be given on the failure to obtain consent.”

Relying for this view on the Canadian case of Malette v. Shulman 47 DLR (4th Edition) 18 and the English case of Sideway v. Board of Governors, Bethlehem Royal Hospital (1985) 1 AC.871, the court below being of the view that only issue in the case was whether the medical practitioner should “proceed to administer the medical measure refused without that consent” it held that: “if 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 e.g. In the case of surgery or blood transfusion as was proposed but aborted in the present case.” The court below in fairness to the Respondent limited itself to optional measures which a medical practitioner will, finding himself entangled, extricate himself from these difficulties as best he could.

This issue (issue 1) as raised in the Appellant’s Brief paragraph 4.1.2 at page 7 thereof, is in my view, no more than an academic exercise and juggling with words. And with regard to Section 33(6)(a) of the 1979 Constitution, which clear requirements impose a duty on all pros-

ecutors to make their charges clear, the courts it ought to be stressed, examine the charges for their substance.

Count 1 of the charge in DENLOYE (supra) and Count 1 in this case are clearly distinguishable in that while Count 1 in DENLOYE (supra) merely alleges that the doctor “did in a prolonged manner neglect....” Without also alleging the doctors’s state of mind or the consequences of his actions, Count 1 in the instant case goes on in its particulars (a) and (b) to detail allegations of knowing the condition of the patient, knowing the correct treatment etc and yet failed to give it or transfer the patient until she died. The alleged acts amount to gross negligence and/or deliberate action leading to death. The court below, in my opinion, made this distinction in its judgment at page 270, line 22 - page 271, line 14 of the records. Further, the court below in its judgment, detailed an analysis of Count 1 and its particulars (see pages 267-269 of the records) to show the gross nature of the negligence. The court below at page 269 line 2 mentioned “Section 301 of the Code (supra)” an obvious but mistaken reference to Section 303, which it mentioned earlier at page 268, line 9. It also mentioned Section 305 (4), of the Criminal Code, evidently meaning Section 305A(4), and stated that it “provides that any person guilty of this offence shall be liable on conviction to a fine of N100.00 or to imprisonment for 6 months or to both such fine and imprisonment. Prosecution for the offence shall be instituted with the written consent of the Attorney-General of the Federation. These references to Section, 301 and 305(4) which have not derogated from the clear analysis and conclusions of the court below were capitalised upon in paragraph 4.3.4. of the Appellant’s Brief in criticizing its decision as regards Count 1. This criticism, in my view, is baseless as the stark analysis and conclusion of the court are correct in every aspect before these references. The end result therefore, is that these erroneous references do not affect the correctness of the conclusions reached by the court below. See the case of Fadlallah v. Arewa Textiles Ltd (1997) 8 NWLR 546 at 550, ratio 6 in which this Court held that “it is not every slip committed by a court that will result in an appeal against the judgment being allowed. An error or slip that may have the result of the appeal being allowed must be fatal in

the sense that it must occasion a substantial miscarriage of justice vide Ezeoke v. Nwagbo (1988) 1 NWLR (part 72) 616.’ Similarly, in Ajuwon v. Akanni (1993) 9 NWLR (part 316) 182 at ratio 18 this Court held inter alia that “*it is not every slip committed by a Judge in his Judgment that amount to a misdirection which will result in the appeal being allowed. B The misdirection, to be fatal, must have occasioned a substantial miscarriage of justice. The mistake must have affected or influenced the appealed against before it can result in the reversal of the decision.*” See also Order 8 Rule 16 of Supreme Court Rules (as amended).

In the result, I take the firm view that Appellant’s contentions be C rejected off hand while the decision of the court below should be upheld.

It is for the above reasons and the fuller ones contained in the leading judgment of my learned brother Ayoola, JSC, a preview of which I had, that I too, dismiss this appeal. I make similar consequential orders D inclusive of costs.

ACHIKE JSC

I had the privilege of reading in advance the judgment just delivered by my learned brother, Ayoola, JSC. The judgment is quite detailed and I entirely agree with the reasoning and conclusions therein and can hardly make further meaningful contributions.

I shall however make some observations. The concluding part F the decision of the Medical and Dental Practitioners Disciplinary Tribunal (hereinafter referred to simply as ‘the Tribunal’) runs as follows:

“We found therefore that although a doctor as well as anybody G 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 this case. For a doctor to collude with those who deny this life saving measure on grounds of religion is unethical to the medical profession. In the event the doctor waited H and watched over the patient until she died 4 days later. That is, without giving other doctors and other health institutions an opportunity to ob-

tain the consent and administer the correct treatment.'

A close reading of the record of appeal shows that the Tribunal was in grave error in its view that the respondent acted in collusion with the deceased and her husband in neglecting to administer the blood transfusion primarily because he held the same religious beliefs with them whereas he ought to have transferred her to another medical officer who might be more disposed to deal with her case less sympathetically of religious beliefs, rather than keep her under his supervision for four days until she died. This to the Tribunal, was an act of serious professional misconduct. The serious fault in this view of the Tribunal is that it was reached without proper evaluation of the evidence placed before it. First, the Tribunal failed to glean from the record and evidence before it that the respondent though of the same religious faith - 'Jehovah Witnesses' faith- had in the past carried out blood transfusion of consenting patients of the same faith. Second, the Tribunal palpably misplaced the emphasis on the respondent's religious beliefs rather than those of the patient whereas there was no evidence before it that it was the respondent's personal beliefs that prevailed on him not to administer the blood transfusion. Again, it was equally unfortunate that the Tribunal completely shut its eyes to the evidence that both the deceased and her husband rejected the offer of discharge and the patient signed a No Blood medical paper. These short-comings were clearly borne out of the judgment of the lower court. Had they been properly addressed or appreciated by the Tribunal, unquestionably the Tribunal would have come to a different decision.

My immediate reaction in reading the record of this appeal wherein the respondent was found guilty of "infamous conduct" was that he was guilty of an offence of such disgraceful depravity involving serious moral turpitude. My feeling was that it was an offence of the highest order that would shock every right-thinking member of society. But it was not to be. It was at best, an omission to do something by a caring medical officer in respect of a complex matter which involved respecting the personal decision-albeit, of religious beliefs- of a patient in the face of the patient's obduracy in being treated. I was relieved that I found nothing

delinquent, not to mention infamous, about the conduct of the respondent throughout the circumstances of the case. The term “infamous conduct” in relation to the imagined offence committed by the respondent, in the circumstances of this case, was clearly misconceived.

It is for the foregoing, and the fuller reasons contained in the leading judgment that I agree that the Court of Appeal rightly reversed the decision of the Tribunal. I too, accordingly would dismiss the appeal with N10,000 costs in favour of the respondent.

UWAIFO JSC

I read in advance the judgment of my learned brother Ayoola JSC. I fully agree with the reasoning and the conclusions reached. I respectfully adopt the judgement as mine. I do wish to emphasise that there is no evidence that the respondent was influenced by his own religious beliefs as a Jehovah’s witness regarding any Biblical injunction against blood transfusion. The Chairman of the Tribunal which heard the respondent’s case cross-examined the respondent. I will quote a relevant question and the answer given to it:

Q. “You said something which I didn’t get quite clear. In case I didn’t get you, correct me. You said she belongs to a special pioneer. What does that mean?”

A. Jehovah’s witness (sic) are categorised into two, one are people if you pressurise, they will accept blood. Two, people who if you pressurise under any circumstance even under the threat of death they will tell you No! Why I mention that is to reflect her deep conviction about her insistence after I have discussed with about the issue of taking blood. That was why that comment went into her note.”

It seems there are those among Jehovah’s witnesses who could be persuaded to accept blood transfusion and that the respondent was willing and did try to explore how to get the deceased to accept. But there is clear evidence both oral and documentary in support of the refusal of the deceased to accept blood transfusion. There is the evidence of Esther Ugwu who said she was a friend of the deceased (Mrs. Martha Okorie).

She said she visited the deceased in the hospital and that she pleaded with her not to leave but to wake her up in case there was an attempt to infuse her with blood. There is also the evidence of Mr. Loveday Okorie, the deceased's husband. He said his wife refused blood transfusion in the first hospital even when the doctor warned her about the consequences of her refusal. She signed a NO BLOOD medical document which was countersigned by himself and the deceased's uncle, one Mr. C.A.Ukwuoma. She was later removed to the hospital where the respondent received her. The deceased handed the respondent the NO BLOOD medical document. The witness said the respondent warned on the consequences to her of refusing blood transfusion but she maintained her stand. The witness signed a document called "Release from liability Form" and gave it to the respondent. The respondent thereafter tried every other treatment he could to sustain the deceased's life but to no avail.

It is clear to me that the Tribunal took a rather hard line against the respondent without feeling obliged to calmly consider the difficult circumstances imposed upon him by the religious beliefs of the deceased and her husband as these came out strongly in evidence, backed by documents. The personal religious beliefs of the respondent did not, in my view, play any part in the scenario in which the deceased and her husband insisted on their fundamental right, which right did not put the welfare of society or public health at risk, as to compel the respondent to assume further responsibilities other than what he had to do in the circumstances.

I am completely satisfied that under normal circumstances no medical doctor can forcibly proceed to apply treatment to a patient of full and sane faculty without the patient's consent, particularly if that treatment is of a radical nature such as surgery or blood transfusion. So the doctor must ensure that there is a valid consent and that he does nothing that will amount to a trespass to the patient. Secondly, he must exercise a duty of care to advise and inform the patient of the risks involved in the contemplated treatment and the consequences of the his refusal to give consent: see *Sideway v. Board of Governors of Bethlehem Royal Hospital* (1985) 1 A. C. 871.

I cannot conceive of the beneficial effect the rules of Professional conduct which the Tribunal relied on in the present case would have had. The tribunal stated that:

“When therefore he (meaning, the medical doctor) is faced with a dilemma arising from the refusal to grant informed consent our code of Ethics prescribed 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”.

If I may ask, how wise would it be to refer a patient who is adamant about not accepting blood transfusion to another doctor or health institution? What method of enforcing life preservation is envisaged that such other doctor or institutions will take? Is there a list of such doctors or institutions, or in what way are they to be ascertained? As to the first option, how can one justify terminating the contract of this peculiar patient? She wanted treatment other than by blood transfusion. The respondent understood the situation and did his best to treat her.

For the above reasons and those fully stated by my learned brother Ayoola JSC, I find no merit in this appeal. I, too, dismiss it with N10,000.00 costs to the respondent.

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