Exploring Legal Defences to Medical Malpractice Claims: Which Way Nigeria?

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Abstract

Medical treatments and procedures entail that every physician and healthcare provider engaged in treatment or patients' diagnosis must exercise duty of care and absence of this duty of care or any deficiency in that duty of care may amount to medical malpractice and can impose liability. Such malpractice may be derived from a doctor's lack of training or experience or from a physician's carelessness or inadvertence. Medical malpractice required that the physician had a duty, the physician breached the duty, there was harm to the patient, and that the harm was caused by the physician's breach of duty. Where the above conditions are met, there are still some special legal defences that can be used in court to exonerate the physician. These defences include contributory negligence, assumption of the risk, clinical innovation, Good Samaritan, respectable minority, two schools thought, to mention but these. This paper aimed at exploring these legal defences to medical malpractices through doctrinal legal research methodology achieved through the use of textbooks, articles in journals and internet materials. It found that medical practitioners are oblivion of some of the defences available to them in medical malpractice cases and claims confronting them on daily basis. It further found that these defences are not generally codified into a single statute. The paper recommended the statutory codification or recognition of the defences available to medical practitioner facing medical malpractice claims. It concluded that knowledge of these legal defences can help medical practitioners minimise their risk of litigation when caring for patients.

Exploring, Uncharted, Legal, Defences, Medical, Malpractices

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1. Introduction

Once a doctor undertakes to treat a patient and the patient-doctor relationship is established, the doctor is required to diagnose and treat the patient with due care.[1] From ancient times the medical practitioners had been held accountable for a failure to exercise reasonable care in treating his patient, independently of any contractual relationship with the patient.[2] In Nigeria, medical practitioners are dedicated to providing competent medical care, with compassion and respect for human rights and dignity.[3] Health care providers owe their patients this duty of care in contract as well as in torts.[4]This duty is imposed by law when the doctor undertakes the task of providing advice, diagnosis or treatment.[5] In *Bateman's* case, Lord Hewart C. J. Was decisive and magisterial when he stated thus:

> If a person holds himself out as possessing special skill and knowledge and he is consulted, as possessing such skill and knowledge, by or on behalf of a patient, he owes duty to the patient to use due caution in undertaking the treatment. If he accepts the responsibility and undertakes the treatment and the patient submits to his direction and treatment accordingly, he owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relation is necessary, nor is it necessary that the service be rendered for reward.

Any deficiency in that due care may amount to medical malpractice and can impose liability. Such malpractice may be derived from a doctor's lack of training or experience or from a physician's carelessness or inadvertence.[6] A physician facing a medical malpractice lawsuit can defend against the claim by arguing that the plaintiff failed to show, by preponderance of the evidence, that the physician's conduct met the elements of the malpractice claim. Alternatively, the physician can argue that the circumstances of the lawsuit preclude a finding of liability, regardless of the persuasiveness

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1 U Abugu, *Principle and Practice of Medical Law and Ethics* (Pagelink Nigeria Limited, Abuja 2018) 157

2 M Jones, *Medical Negligence* (London, Sweet and Maxwell 1996) 33

3 Code of Medical Ethics in Nigeria, 2008, section 3.1

4 G Dieter, *International Medical Malpractice Law: A Comparative Study of Civil Liability Arising from Medical Care* (Dordrecht, Tubingen Publisher, 1988) 73

5 *R v Bateman* (1925) 19 Cr App 18

6 *Ibid* (n 1)159

of the plaintiff's case. These affirmative defences are available to defendants in civil suits generally, though physicians facing malpractice claims have some recognised defences.[7] This paper, therefore, explores profoundly those defences.

2. Medical Malpractices

Medical malpractice cases are essentially based on whether or not medical professional violated what is known as the standard of care. This means that the doctor did not provide a level of care consistent with what the regulations demand.[8]Additionally, if a doctor's medical negligence led to his patient sustaining an injury that resulted in significant damages, his case may qualify as medical malpractice. Here are some examples that qualify as medical malpractice:

2.1 Lack of Due Care

Once a doctor undertakes to treat a patient and the patient-doctor relationship is established, the doctor is required to diagnose and treat the patient with due care. Any deficiency in that due care may amount to medical malpractice and can impose liability.[9] Such malpractice may be derived from a doctor's lack of training or experience or from a physician's carelessness or inadvertence. In the first situation, doctors may be held liable because they should have recognised their inadequacy and referred their patients to better-trained doctor's or specialists. In the second instance, perhaps they should have conducted more thorough investigations or examinations.[10]

Perhaps they should have visited their patients more often. In other words, they should have been more 'diligent.' According to Jones,[11] these two requirements: (a) skill and knowledge, and (b) diligence-comprise the legal and ethical bases for application of the tort law because of inadequacies in the care of a patient. Once it is established that the medical practitioner owed a duty of due care to the patient, the matter of whether or not there has been a lack in that due care must be

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7 Lawshelf Educational Media, Medical Malpractice: Causation, Defenses and Damage, available at <https://lawshelf.com/videocoursemoduleview/causation-defences-and-damages-module-3-of-5>accessed on 5th May 2025

8 Walker Medical Law, (2019) available online at <https://www.peltzwalker.com/defences-against-medical-malpractice-claims/> accessed on the 5th May 2025

9 *Ibid* (n 1)157-159

10 *Ibid*

11 M Jones, *Ibid* at 33

settled. The test is both subjective and objective. The medical practitioner who knowingly exposes the patient to a substantial risk or loss lacks due care. The medical practitioner who fails to realise the substantial risk or loss to the patient and which any reasonable man of the same profession and in the same situation would clearly have realised, also lacks due care.[12] It is settled that medical practitioners must exercise the standard of skills, which is usual in their profession, and it is no defence that they acted to the best of their skill if such skill falls below the required standard.[13]

The issue of what standard of due care is required of a medical practitioner is one of great concern. There are differences of opinion and different philosophies on the standard of due care for medical practitioners. Despite the variety of formulations which have been offered by both the courts and jurists, the best known and most often quoted definition of the standard of due care required of medical practitioners is McNaie J's direction to the jury in the *Bolam's case,*[14] commonly called the *Bolam Test.* It is to the effect that where there is a situation which involves the use of some special skill and competence, the test as to whether there has been a lack of due care is the standard of the ordinary skilled man exercising and professing to have that special skill. The law does not require the doctor to attain the highest or lowest standard. It is sufficient if the doctor exhibits the degree of care, skill and judgment which an average doctor of that experience, placed in the same circumstance would show.[15]This standard will of course vary according to the skill expected of the individual doctor. A house officer is not expected to show the same standard of skill and care as a consultant working in a special area.[16]

On the other hand, if in an emergency or during a hospital strike, circumstances compel a doctor to render medical service in an area outside the doctor's specialty, the law will not require the doctor to conform to the standard of specialists in that area of medicine but to

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12 *Ibid* note 13

13 *Ibid*

14 *Bolam v Frien Hospital Management Committee* (1957) 1 WLR 582 at 586; (1925) 19 Cr App R 8

15 *Ibid*

16 B C Umerah and others, *Medical Practice and Law in Nigeria,* (Enugu, Longman Nigeria, 1989) 132

the standard of an average doctor of similar experience working in similar circumstances.[17]

2.2 Lack of or Improper Consultation, Reference and Diagnosis

One of the duties that are derived from the patient- doctor relationship is the duty to obtain timely and adequate consultations whenever it is indicated or to refer the patient to the appropriate specialist or facility whenever the requirements for the appropriate or specialised care cannot be satisfied by the referring doctor or doctors available at the facility.[18] Consultation implies a review of the medical records and examination of the patient by the consultant. There are situations in a healthcare facility when doctor's may seek medical advice from their colleagues. Such often very informal discussion do not qualify as consultations. A consultation is required whenever (a) the diagnosis is obscure, (b) there is doubt as to the best therapeutic approach, (c) the patient is not progressing well, or (d) the primary doctor is not qualified to treat the condition. Ordinarily, it is preceded by submission of a formal 'Consultation Request Sheet', followed by the preparation of a written report signed by the consultant and incorporated within the medical or hospital record.[19] Referral is a further step. A doctor is generally held to have a duty to consult or refer to another doctor whenever the patient's condition does not progress under treatment as would have been normally expected.[20] In the Code of Medical Ethics in Nigeria, 2008, it is provided expressly that practitioners shall not hesitate to seek the consultation of more experienced or appropriate specialist colleagues whenever they are in doubt or lacking competence with regard to the medical needs of their patients.[21]

Similarly, a consultant with a lesser degree of specialisation may have a duty to consult or refer to one who has a high degree of specialists knowledge whenever the primary consultant knows or should know that patient's condition is not progressing as it should. In other words,

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17 *Ibid*

18 Duty to consult. Rules 3.5; 3.11; 11.2; 41, Duty to refer Patient to Medical Specialist, Rule 41.1, Code of Medical Ethics in Nigeria, 2008

19 Blackman and Bailey, *Liability in Medical Practice* (London, Harwood Academic Publisher, 1990) 106

20 *Manion v. Tweedy*, 100 NW 2d 124. Minn, 1959.

21 Rule 3.11

a specialist may have to consult with or refer to a super specialist.[22] However, whenever a doctor discovers that a particular medical problem is beyond his capacity for diagnosis or proper care, failure to call for consultation or to make reference might, by itself, attract liability.[23] Errors in diagnosis may arise for various reasons, such as: inadequate medical history; errors in examining the patient; errors of judgement in interpreting the patient's symptoms; failure to spot something 'serious'; failure to conduct tests; or failure to monitor treatment and reverse the diagnosis where the treatment is providing ineffective.[24]

Generally, it is expected of any doctor to possess adequate medical knowledge (based upon education, training and/or experience) and that he applies his medical skills in such a manner and with such diligence as would ordinarily be expected to enable him provide accurate diagnosis.[25]In order to do this, the doctor may rely upon the patient's history, results of the physical examination, the appropriate non-invasive and invasive laboratory tests, consultations, conference considerations and referrals.[26] Where the doctor fails to avail himself of the scientific means and facilities available for the collection of the best factual data in forming their diagnosis, the result will not be considered error of judgement but negligence in failing to secure adequate factual bases upon which to support their diagnosis.[27]

> Failure to utilise the appropriate tests upon which a diagnosis could be based or to obtain consultation or referral may be considered equally negligent. But once the doctor has utilised the appropriate tests upon which a diagnosis could be based, failure of the patient to accept the diagnosis will automatically shift any liability that might arise from such a situation from the doctor to the patient.[28]

2.3 Errors in prescribing and treatment or mistreatment

Today, drug administration contributes an appreciable percentage of medical malpractice in Nigeria. However, this represents only a

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22 *Ibid* (n 13)166
23 *Ibid*
24 *Ibid*
25 *Ibid*
26 *Ibid*
27 *Ibid* at 169
28 *Mrs. Deborah Agree v Dr. S. Ojobo (doing business under the name and style of Ponder End Clinic)* Unreported, suit No. B/595/94

fraction of presently recognised cases of adverse drug reactions, interactions and abuse.[29]Also, doctor's must have the degree of skills including training and medical judgement that is possessed by the average doctor of the same training and skill. They must also use the same degree of diligence in applying this skill as the average doctor's would be expected to apply.[30]In Nigeria today, there are many situation whereby an error in treatment or a mistreatment could be said to have occurred. Such situations are: unintentionally leaving foreign bodies within a patient, operation or treatment on the wrong patient or the wrong part of a patient, blood transfusion, gynecological malpractice and injury during exposure to x-rays. Generally, Rule 28 of Code Medical Ethics in Nigeria 2008 makes provisions for a range of actions which will constitute medical negligence or malpractices such as:

a) Failure to attend promptly to a patient requiring urgent attention when the practitioner was in a position to do so.
b) Manifestation of incompetence in the assessment of a patient.
c) Making an incorrect diagnosis particularly when the clinical features were so glaring that no reasonable skillful practitioner could have failed to notice them.
d) Failure to advise or proffering wrong advice to, a patient on the risk involved in a particular operation or course of treatment, especially if such an operation or course of treatment is likely to result in serious side effects like deformity or loss of organ.
e) Failure to obtain the consent of the patient (informed or otherwise) before proceeding on any surgical procedure or course of treatment, which such a consent was necessary.
f) Making a mistake in treatment e.g. amputation of the wrong limb, inadvertent termination of a pregnancy, prescribing the wrong drug in error for a correctly diagnosed ailment, etc.
g) Failure to refer or transfer a patient in good time when such a referral or transfer was necessary.
h) Failure to do anything that ought reasonably to have been done under any circumstance for the good of the patient.
i) Failure to see a patient as often as his medical condition warrants or to make proper notes of the practitioner's observations and prescribed treatment during such visits or to

[29] *Ibid* (n 13)173
[30] *Ibid*

> communicate with the patient or his relation as may be necessary with regards to any developments, progress or prognosis in the patient's condition.

Therefore, failure to diagnose or misdiagnosis, Anesthesia errors, Failure to order proper testing, failure to recognize symptoms, misreading or ignoring laboratory results, unnecessary surgery, premature discharge, hospital infections, surgical errors, wrong-site surgery, improper medication or dosage, poor follow-up aftercare.[31]

3. Defences to Medical Malpractice Claims

There are four elements that must all be present in order for a physician to be held liable for damages in a malpractice suit. These elements are that: 1) the physician has a duty, 2) the physician breached the duty, 3) there was harm to the patient, and 4) the harm was caused by the physician's breach of duty. If all four conditions are not met, the physician is not held liable.[32]If all four conditions are met, a *prima facie* case of malpractice or negligence is established. In order words, there is proof that malpractice exists.[33] It is apposite that some discussions on these elements be made here and briefly.

3.1 Duty of Care

The ultimate question is does the medical practitioner owe the patient a duty of care under the circumstances of the case? For a duty of care to exist, there must be a fiduciary relationship between the medical practitioner and the patient. This fiduciary relationship can be formed easily without a formal consent by the patient. In *R v Bateman*[34]the court explained that, if a person holds himself out as having special skill and knowledge and he is consulted, as having such skill and knowledge, by or on behalf of a patient, he owes a duty to the patient or client to use due caution, diligence, care, knowledge and skill in administering treatment.[35] To determine whether a duty of care exists, the court would ask itself, whether there is proximity between the

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31 *Ibid* (n 13) 173
32 *Ibid* (n 8)
33 *Ibid*
34 (1925) 19 Cr App R 8
35 D Bryden and I Storey, 'Duty of Care and Medical Negligence' (2011) *Continuing Education in Anesthesia*, Critical Care & Pain. Volume 1

patient and the medical practitioner. Also, hospital authorities owe the same duty of care to patients accepted for treatment in their hospitals[36]

3.1 The Duty of Care was breached

After a duty of care is established, the next step is to determine whether the conduct of the medical practitioner towards the patient amounts to breach of the duty of care. The patient must prove that the medical practitioner acted below the standard of care expected of him in his professional capacity. This however, raises the question of the particular standard of care required of a medical practitioner in the treatment of a patient. The standard the court use is the objective standard. The court expects the standard of a reasonable man in the identical situation. The determination of the relevant standard of care involves an assessment level of skill, knowledge, and experience that could reasonably be required of a practitioner with the same professional standing as the defendant. In *Bolam* v *Frien Hospital Management Committee*[37] the reasoning was succinctly articulated as follows; ' a doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of men skilled in that particular act'.[38]

3.2 As a Direct Result of the Breach the Patient Suffered Harm

Not every negligent act can cause damage which will give rise to an action in tort. For a patient to succeed in an action of negligence, the patient must prove that the injury or damages was caused by the medical practitioner's breach of duty of care. If the patient cannot prove that the damage was not too remote to the negligent act of the medical practitioner. There must be a direct nexus between the negligent act and the damages[39] In *Ajaegbu v Etuk*[40] the plaintiff was unable to establish that the damage suffered was a result of the breach

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[36] B Ogundare, Medical Negligence in Nigeria: A Quick Guide on Liabilities and Remedies (2019) available online at:https://www.researchgate.net. publication/ 337098757. Medical Negligence in Nigeria: A Quick Guide on Liabilities and Remedies (accessed on 20th May 2025)

[37] (1957) 1 WLR 582 at 586

[38] *Ibid*

[39] K Zontong, 'An analysis of the proof of medical negligence under Nigerian Law' (2015), <https://www.academia.edu/30223225/An Analysis of the Proof of Medical Negligence Under Nigerian Law> accessed 20th May 2025

[40] (1962)6 ENLR. 196

of duty by the medical practitioner and the medical practitioner was not liable.[41]

The onus of proof lies with the claimant, and usually, if a medical practitioner does not admit negligence in a given case, then the claimant will have to call evidence to show negligence on the part of the medical practitioner i.e. to show that the conduct of the medical practitioner fell below the required standard in a particular case. A hospital will be vicariously liable if its staff is negligent in the performance of their duties. This is based on the general principle that an employer is liable for the act of its employee in the course of his employment. This principle was recognised in the case of *Igbokwe v UCH Board of Management,*[42]where Iwing J held thus; 'It is now seemed too well settled that a hospital authority is responsible for the acts or omission of the whole of its staffs, whether they were physicians, doctors, nurses or other employees'

Medical Malpractice is a form of negligence; therefore many of the defences allowed against general negligence claims are also viable against malpractice claims. For example, a doctor may argue that his care was in line with the standards set by or upheld in the medical profession or that the patient's injuries were not the result of a medical error.[43]Another possibility is that the doctor blames another entity for the harm you suffered. For example, they may argue that a piece of equipment malfunction because it was defective.[44]While disproving an element of negligence is one of the most common defences to medical malpractice, there are a number of other defenses that may apply as well. They are as follows:

3.3 Contributory Negligence

Where the damage which the plaintiff has suffered has been caused partly by his own negligence and partly by the negligence of the defendant, then the damages which the plaintiff can recover from the defendant may well be reduced because of the plaintiff's contributory negligence.[45] A person is guilty of contributory negligence if he ought

41 *Ibid*
42 [1961] WNLR 173
43 *Ibid*
44 *Ibid*
45 E D Pitchfork, *Text Book on Tort* (8th Edition, London, HLT Publisher 1994) 159

reasonably to have foreseen that if he did not act as a reasonable prudent man, he might hurt himself, and in his reckonings he must take into account the possibility of others being careless.[46]

Once the issue of contributory negligence has been raised by the pleadings, the plaintiff has the burden of proving that he was in the exercise of due care at the time and was free from contributory negligence.[47] The Defendant (medical practitioner) has the burden of proving the plaintiff's contributory negligence. To prove this, the defendant need not prove that the plaintiff owed him a duty of care. It is sufficient if the defendant proves that the plaintiff did not take reasonable care and contributed, by this want of care, to his own injury.[48]

Contributory negligence in medical malpractice can take the form of failure to follow a physician's instructions for proper care following medical treatment can eliminate or reduce the physician's liability for ensuing injury.[49] In *Shelton* v *United States*,[50] a doctor was found negligent for failing to prescribe antibiotics to a patient who was bitten on his finger. However, the damages awarded to the plaintiff were reduced due to his failure to follow the doctor's discharge instructions to seek immediate medical care if he developed an infection. Moreover, failing to provide an accurate account of symptoms or a complete medical history may be contributory negligence. For example, a jury may find that a patient contributed to his own death by heart attack if he failed to inform the treating physician that he was experiencing chest pains after being asked by the doctor.[51]

Note that a plaintiff's negligence can reduce damages proportionally to the harm contributed but does not necessarily preclude recovery follow

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46 *Jones* v *Livox Quarries Ltd*(1952) 2 Q. B. 608 per Lord Denning

47 M C Hoyt, 'Contributory Negligence as a Defence in Malpractice Litigation' *Chicago-Kent Law Review* [1967] (44) (2) 148. Available at https://scholarship.kentlaw.iit.edu/cklawreview/volume 44/issue 2/10 accessed on the 5th May 2025

48 B C Umerah, *Medical Practice and the Law in Nigeria* (Lagos, Longman Nigeria Ltd 1989) 128

49 *Ibid* (n 8)

50 804F. Supp.1147. 1159 (E. D. No. 1992)

51 *Fall v White,* 449 N.E 2d 628, 632 (Ind. Ct. App 1983)

the defendant's negligence.[52] The conduct alleged to constitute contributory negligence may occur either contemporaneous with or after the negligent conduct of the physician. Some of the acts held to constitute contributory negligence are (a) failure to return for further treatment, (b) not following instructions, (c) refusal of suggested treatment, (d) failure to consult another physician when dissatisfied with treatment being received, and (e) ordering the doctor to treat in a manner which he does not recommend.

3.3.1 During Treatments

More commonly, it is the conduct of a patient during the course of treatment which is pleaded as a bar to malpractice. In *Wesley v Allen*,[53]by way of a much cited dictum, the court stated:

> If a patient is guilty of contributory negligence which is an active and efficient contributory cause of the injury occasioned by the malpractice of his physician he is not entitled to recover. In other words, contributory negligence simultaneous and cooperating with the fault of the physician and entering into creation of the cause of action and forming an element in transaction which constitutes the cause of action will bar a recovery.

Frequently the contributory negligence complained of is a failure to cooperate with the physician. A failure to cooperate would bar an action. In the case of *Hearing* v *Spicer,*[54]the defendant-doctor was called to treat the plaintiff two days after she had been injured. Due to the inflamed and swollen condition of the plaintiff's injured shoulder and her resistance to the examination, it was difficult to discover the extent of the injury.

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52 *Ibid* (n 8)

53 235 III. App. 322 (4th Dist. 1925). In *Wesley* v *Allen, the* plaintiff, while in the scope of his employment, injured his finger. He alleged that the defendant failed to amputate it but instead carelessly dressed it. As a result, the finger became so badly infected that plaintiff permanently lost the use of his right hand armed. The court, based it's decision on the statute of limitations and an estoppel due to accepting as full satisfaction of his injuries as award of $2856 under the Workmen's Compensation Act. Nevertheless, this case has been widely cited for the definition of contributory negligence.

54 92 III. App. 449 (3rd Dist.1900).

Only by use of a general anesthetic could a more general examination have made, and for that an assistant would have been required. The evidence conflicted as to whether the defendant knew from the examination he did make that the plaintiff's shoulder was dislocated. The evidence also conflicted as to whether the defendant requested that the patient's husband obtain an assistant for the defendant-doctor.

The appellate court reversed the trial court and held that the jury should have been instructed that it is the duty of a patient to follow all reasonable advice and, if the doctor requests needed assistance and the plaintiff refuses or neglects to procure it, the physician cannot be held liable for an injury which would have been prevented had assistance been procured. Similarly, in the case of *Littlejohn* v *Arbogast*,[55] the plaintiff suffered serious injuries to his back and hip due to a fall. The defendant was called in to treat the injuries. The vital issue to be decided was whether the defendant was negligent in failing to properly treat the dislocated hip. The defendant contended that he knew of the dislocated hip, but did not immediately set it, for such action would have seriously endangered the plaintiff's life, as the plaintiff was also suffering from a dangerous spinal injury.

After the plaintiff had somewhat recovered, he refused to allow the defendant to administer the anaesthetic necessary to reduce the dislocation. The court, in reversing the trial court, held that the patient was under a duty to submit to the necessary treatment prescribed by his physician and, when he refused, the physician could not be held liable for injuries flowing from his failure to administer the refused treatment. In both of these cases, the plaintiff suffered injury due to improper treatment being rendered. However, in both cases, the plaintiff was the cause of the treatment being improper. It was the patient's failure to cooperate with the doctor that caused the injury and prevented the doctor from performing acts which would have resulted in no injury being done.[56]

These cases suggest that though the plaintiff may be negligent during the course of treatment, he may still recover if his negligent acts occur subsequent to the negligence of the defendant. The important moment in time is the time during which the medical practitioner performs the

[55] 95 II. App. 605 (3rd Dist.1900)
[56] *Ibid*

act that is alleged to be negligent. If some negligent act of the patient has an adverse effect on the physician's treatment at the time he administers that treatment, and, if not for the patient's acts, the injury complained of would not have occurred, then the cause of action may be defeated by the defence of contributory negligence.[57]

3.3.2 After Treatment

In general, an injured person is under a duty to mitigate his damage.[58] This duty is bound up in the rule of avoidable consequences. The rule of avoidable consequences operates on the negligence of a plaintiff which takes place subsequent to the legal wrong that has occurred, but while some damages can still be averted. The problem raised when the plaintiff's is contemporaneous with or prior to the defendant's and contributes to the extent of the injury sustained, though not to the cause, is more difficult to resolve. Decisions are split as to whether the plaintiff should recover for the entire injury sustained, or only for those injuries not flowing from his own acts. In either case, however, the plaintiff does recover something. Subsequent negligence operates to aggravate the injury already done, and the rule of avoidable consequences bars recovery of those damages that could have been avoided had the plaintiff adhered to the standard of the reasonable man.[59]The decisions of the court in *Wesley's* case follow this line of reasoning. The court, by way of a dictum, summed up the rule most adequately:

> Where the negligence of the patient is subsequent to the malpractice and merely aggravates the injury inflicted by the physician, it only affects the amount of the damages recoverable by the patient. Such negligence will simply prevent a recovery to the extent that the damages were thereby enhanced or increased.[60]

It has been held that the plaintiff is under a duty to follow the reasonable directions of his doctor, and, in the absence of directions, he is required to exercise the ordinary care of a reasonable man in a

[57] *Ibid*
[58] *Devlin* v. *Chicago City Ry. Co*, 210III. App. 7 (1stDist 1918)
[59] (n 47)
[60] 235 III. App. 322 (4th Dis. 1925)

like situation.[61]If he does not, and this conduct is subsequent to any negligence of his physician, there will be no compensation recovered to the extent that this conduct aggravates the injury initially caused by the physician. Subsequent negligence on the part of the patient does not discharge the doctor's liability, but it does mitigate damages.[62] However, not every failure to follow a doctor's instructions results in a mitigation of damages.[63] Though plaintiff may be charged with negligent conduct that occurred before, during, or after treatment, only that conduct which occurs simultaneously with the alleged misconduct of defendant will serve to completely discharge defendant of his liability. Negligence which occurs prior to the defendant's negligence is of no effect at all. Negligence which occurs subsequent to the defendant's negligence can only serve to mitigate damages.[64]

3.3.3 Voluntary Assumption of Risk (Defence of Consent)

This is where the patient has expressly given his consent to relieve the specialist from liabilities and has decided to take his chances of injury from a disclosed risk. Scenario like this may arise where an experimental treatment is to be embarked on by a specialist who makes known the risks involved. He will be free from liabilities if the patient voluntarily assumes the risks as such action will serve as a waiver.[65] Under the Torts Law, no injury is done to one who voluntarily consents (*Volenti non fit injuria)* is a complete defence to an action in negligence.[66] If a plaintiff, with full knowledge, voluntarily accepts the risk of injury, he or she will not recover any damages.[67] The defendant needs to prove not only that the plaintiff accepted the risk of injury but also accepted that if injury should happen, the plaintiff would accept the legal risk.[68]

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61 *Ibid*

62 *Doyle* v *Owen,* 150 II. App. 415 (2d Dist. 1909

63 *Morris* v *Despain* 104 III. App. 452 (2d Dist. 1902

64 *Ibid*

65 D Momodu and T I A Oseni, 'Medical Duty of Care: A Medico-Legal Analysis of Medical Negligence in Nigeria", *American International Journal of Contemporary Research* [2019] (9) (1) 56

66 *Rootes* v *Shelten* (1967) 116 CLR 383

67 Jennifer Yule, Ibid at 56

68 *Canterbury Municipal Council v Taylor* [2002] NSWCA 24; *Smith v Charles Baker & Sons* [1891] AC 325

The doctrine of voluntary assumption of risk protects doctors in cases in which a patient knew that a medical intervention was risky, but nevertheless consented to undergo the treatment. The law may preclude or limit recovery when a patient suffers harm in such cases of known risks.[69] One such case involved a woman who refused a blood transfusion prior to a procedure despite her doctor's warning that it was necessary. Subsequently, the doctor negligently lacerated the patient's uterus, and the woman bled to death. While the court held the doctor liable, the amount awarded was reduced since it was determined that the refusal of the transfusion was partially responsible for her death and constituted a knowing assumption of the risk.[70]

Most medical practitioners stand to rely on the defence of consent where there are allegations against them for medical negligence, that the patient consented to the treatment forgetting the fact that the patient only consented to proper management of sickness.[71] As the case may be, the law will either imply consent or give the practitioner the benefit of the defence of private necessity under consent.[72] Consent obtained by fraud is no consent. So also is consent given by a patient who is under the influence of drugs or anesthesia and thus is unable to understand fully what is being consented to. Thus, a doctor is required to give the patient sufficient information about the ailment, the treatment proposed as well as the possible risks so as to enable the patient understand the position fully and make an intelligent decision. The doctor should not minimise the risk.[73]

In Nigeria, necessary details are often not communicated to patients. This is due to the fact that because of poor educational background most patients rely on the doctor's judgement for serious cases. The majority of hospital's surgical procedures are expressly authorised by the patient's having signed a consent form, such a consent will not protect a surgeon from liability for negligence in the course of the procedure, neither will it permit the surgeon to undertake a procedure going beyond the consent of given or going on a voyage of exploration

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69 *Well v Seltzer lll*873 F 2d 1453, 1458 (D.C. Cir 1989)

70 *Shorter v Drury,* 695 P 2d 116, 123 (Wash 1985)

71 E Okojie, Professional Medical Negligence in Nigeria, available at: https://www.nigerianlawguru.com>torts, (accessed on 17th June 2025

72 *Ibid*

73 *Ibid*

unless the treatment creates an emergency situation which consent to the additional procedures cannot be obtained immediately. It is to meet this last point that consent forms commonly include consent by the patient to such further or alternative operatives measures as may be found to be necessary during the course of the operation.[74]

There are three situations that give rise to the defence of assumption of risk.[75] The first occurs when the plaintiff has expressly given his consent to relieve defendant from a duty and has decided to take his chances of injury from a known risk. The second occurs when the plaintiff, with knowledge of the risk, voluntarily enters into some relation with the defendant which will probably result in encountering the known danger. The third situation exists when the plaintiff becomes aware of a risk already created by the negligence of the defendant and elects to continue in the face of danger. All the three require that the plaintiff has knowledge of the danger that is to be encountered and voluntarily elects to meet it. If the plaintiff's decision to take the risk is in in itself unreasonable, below the standard of the reasonable man, the conduct is a form of contributory negligence. Due to this overlap, many courts fail to distinguish between contributory negligence and assumption of risk.[76]

The difficulty in applying assumption of risk to case of medical malpractice is that plaintiff must be shown to have knowledge of the risk assumed and to have voluntarily chosen to meet that risk. Proving these two elements is difficult at best. A patient may be aware of the dangers inherent in various medical procedures, but he rarely has any real choice in selecting the treatment given. When he is offered alternatives, both being thoroughly explained, the charge of negligence is most often grounded in an improper execution of the technique or procedure selected, rather than in an improper selection of the technique or procedure utilised.[77]

Another factor, peculiar to cases of surgery and emergency treatment, which makes assumption of risk inapplicable is the usual unconsciousness of the patient at the time of the alleged negligence of

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[74] Eric Okojie (*ibid*)
[75] *Ibid*
[76] *Ibid*
[77] *Ibid*

the physician. A patient who has neither control over what is being done, nor awareness of the physician's activities, cannot be said to have had knowledge of the risk assumed coupled with a voluntary election to meet it. However, under such circumstances, it would be equally difficult to prove contributory negligence.[78]

3.3.4 General Practice

The general rule is that a defendant charged with negligence can clear himself if he shows that he has acted in accordance with the general and approved practice. Therefore, a man whose calling in life involves him in creating situation of danger will usually be justified in following the practice which his trade or profession has adopted or approved for dealing with such situations and he will not be convicted of negligence merely because he has failed to make use of every precaution which ingenuity might suggest.[79] But, when there is developing knowledge of new risks he must take reasonable efforts to keep abreast of it. In malpractice cases the mere fact that the defendant has deviated from the normal practice cases is not enough for many advances in medical sciences have many of such deviation.[80] The choice of accepted medical practice as the criteria governing the disclosure of risks which supports the view that a doctor owes no duty to warn of normal risks, such as infection, and those created by an anaesthesia which are inherent in any surgical procedure and the view that doctor's clinical assessment of the patient's condition may justify the withholding of information in the patient's interest.[81]

Examples given to this second situation are cases in which the information may cause psychological damage to the patient cases in which the patient is too ill to access information properly and where the information may raise undue alarm in the patient and create a risk of a refusal to accept beneficial treatment. Thus, a physiotherapist has been held to owe the patient a duty to give adequate warning to enable him to know the danger inherent in certain procedure and a hospital

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78 *Ibid*

79 Salmon and Houston, *The Law of Tort* (8thEdition,London, Sweet and Maxwell) 218

80 *Strokes v Guest* (1908) 1 W.L.R

81 E Okojie, *Professional Medical Negligence in Nigeria* (Benin, Uniben Press, 1998) 12

was also held liable not to have informed a patient clearly that his treatment was not completed.[82]

The emphasis placed by the law on compliance with accepted professional practice might likely act as a disincentive to innovation that might prove beneficial to the society. The law balances the conflicting interests in this area by a departure from accepted practice as not itself constituting negligence, but requiring the practitioner who chooses to experiment to justify his actions by recourse to the reasoning which underlined them. In medical treatment, the use of experimental procedures likely to require a full disclosure to the patient of possible risks as well as the provision of an increased level of post operative care. It is clear that the courts approach experimental treatment strictly and seek to ensure that a professional person who chooses to undertake such work has considered all the information available on the techniques in question, and has access to the results of empirical research in any question of doubt that remains, and has taken reasonable care to think the problem through so as to attempt to identify any particular difficulties posed by his suggested solution.[83]

The medical profession has been left to set its own standards on the disclosure of risk, except in those rare cases in which a court is prepared to condemn the medically accepted practice as unreasonable. These principles are to be found in the classic statement given by McNair J in *Bolam v Friern Hospital Management* Committee[84] However, in determining whether a medical practitioner exercised reasonable care and skill, the court considers whether he acted as a competent professional within his field. The court may also consider with regards to the practice of other practitioners of similar status.[85]

3.3.5 Good Samaritan

One of the unintended consequences of the high incidence of medical litigation in some jurisdictions is that people with medical skills which

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[82] *Coles v Reading & District Hospital Management Committee and Another* (1963) 107S. J. 115

[83] Walker Medical Law (n 12)

[84] (1957) All ER 118, 221-2, where the plaintiff has suffered fractures as a result of the administration of electro-convulsive therapy without an anaesthetic, the judge ruled that a doctor would not be negligent if he acted in accordance with the practice accepted by a responsible body of skilled medical men.

[85] *Ibid*

could be useful in emergencies are reluctant to offer help because of the fear of litigation should anything go wrong. In the United States of America for instance, doctors and other health workers could pass by road traffic accident scenes and refuse to offer their expertise because of this risk. To stem this unhealthy trend in that country, some states brought legislation to limit actions in negligence arising from medical aid rendered under such emergency conditions.[86]

The Good Samaritan Law as this legislation is known was therefore enacted in some countries to protect from liability, those who volunteer to aid the injured following accidents or sudden illness.[87] This Law derived its title from the biblical account of a man traveling from Jerusalem to Jericho who was robbed by armed men but was rescued and cared for by a Good Samaritan.[88]

Good Samaritan laws were enacted specifically to protect physicians responding to emergency situation. The law wants physicians to respond to emergency situations rather than ignore them for fear of potential litigation.[89]The need to encourage physicians to render emergency medical care when they otherwise might not prevail over the policy of vindicating rights of a malpractice victim.[90] Before the Good Samaritan laws, when a physician helped someone in an emergency in an out-of-hospital setting, they entered into a 'doctor-patient relationship,' which made them liable. Under Good Samaritan laws, physicians responding to emergencies are protected from being held liable for injuries or damages occurring during the emergency.[91]

Physicians are under no obligation to treat people simply because they need medical assistance but are open to liability for negligence if they do provide treatment negligently, even if the physician is not being

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86 E M Osuagwu, *Ethics and Medico-Legal Aspects of Medical*, Jaron Industries Limited,(2010) 125

87 *Ibid*

88 Gospel of Mark 10:30-37

89 M J Hudson and G P. Moore, 'Defences to Malpractice: What Every Emergency Physician Should Know,' *The Journal of Emergency Medicine*, (2011) (41) (6) 599

90 *McKenna* v. *Cedars of Lebanon Hospita*l. Court of Appeal of California, 1979 93 Cal. App. 3d 282, 155 Cal.Rptr. 631.

91 S R Reuter, Physicians as Good Samaritans. Should they receive immunity for negligence when responding to hospital emergencies? *J Leg Med* (1999) (20)157

paid. As such, there is a strong incentive for physicians not to treat people outside of the course of their regular practices, even in cases of emergency.[92] If you are a doctor and come to someone's aid in an emergency situation, you will most likely be protected from civil liability in the event of an injury during rescue.

It follows that although there is no legal obligation upon a doctor to play the 'Good Samaritan' and render assistance to a stranger who has been involved in an accident, a doctor who chooses to do so will owe a duty to treat the patient with due care.[93]The duty arises from the very fact of undertaking to treat or provide care.[94] In an emergency situation, the rescuer must obtain consent from the victim before rendering help where the victim is conscious. Normally, he should introduce himself and request the victim for permission to help. This is important because if rescue effort is made without such consent, it may be interpreted as assault and battery. Consent may, however, be implied if the victim is unconscious, intoxicated with drugs or alcohol, mentally unfit and a minor and parents or guardian are not immediately reachable.

The Good Samaritan law is applicable to negate liability if the person rendering help or first aid is acting: in an emergency, in good faith, without compensation and is not guilty of malicious or gross negligence towards the victim.[95] Once he has responded to the emergency, he must not leave the scene unless it is necessary to call for essential medical assistance or another rescuer takes over is dangerous or unsafe to continue the aid effort.[96] In jurisdiction where the Good Samaritan Laws apply, the courts will be lenient and will not find the volunteer liable provided he complies with the requirements and also confines himself to the level of his training.[97]Although Good Samaritan Laws apply in countries whose legal systems are based on the English Common Law, there is no such enactment in Nigeria. Nonetheless Nigerians out of their cultural ethos and belief that peril

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92 Law Shelf Educational Media Available online at https://lawshelf.com, accessed on the 19th day of June 2025

93 Though in an emergency less may be expected of the doctor to achieve the standard of reasonable care

94 *Ibid*, note 1 at 159

95 *Ibid*

96 *Ibid*

97 *Ibid*

invites rescue, still volunteer to aid those requiring such help despite the high risk nature of such endeavour.[98] The most frustrating experience of good Nigerians who volunteer their help under such circumstances are:

a. The seeming uncharitable and at times overzealous demands from some law enforcement officers requiring them to report repeatedly to the police to shed more light on the circumstances of the accident and/or to explain their role.
b. The demand of some hospitals both private and even government established health facilities, that the good Nigerian who has used his resources to transport the victim to hospital, should in addition, deposit money for the initial treatment of the victim.[99]
c. The spate of kidnappings in Nigeria including that of medical personnel has made it very difficult for people to volunteer to help accident victims. At the back of their minds is the possibility that the 'accident was faked to act as a snare![100]

It is quite encouraging that the Senate has at least done something in this direction. 'A bill for an Act[101] to make provisions for the compulsory treatment and care for the victims of gunshots and other matters connected therewith' has been passed. Among the provisions of the Act are that:

a. No person with gunshot wound shall be refused immediate and adequate treatment by any hospital in Nigeria whether or not initial monetary deposit is paid.
b. No person with a bullet wound shall be subjected to inhuman and degrading treatment or torture by any person or authority, including the police or other security agencies; and

[98] *Ibid*
[99] J C Otteh, How The Lagos Coroner's Law Touches Lagosians' Life, The Guardian, Sunday August 3, 2008 at P 73
[100] Ibid at 146
[101] Compulsory Treatment and Care for Victim of Gunshots Act 2017

c. Volunteers or helpers of victims shall be treated with respect and shall not be subjected to unnecessary and embarrassing interrogation in their genuine attempt to save life.[102]

The emergence of this Act is indeed a welcome development into our medical jurisprudence. The Act seems to be the only Nigerian Legislation that statutorily recognised the concept of Good Samaritan as a defence under medical malpractice.

3.3.6 Respectable Minority Principle

The respectable minority rule is the concept that when it is shown that a respectable minority of physicians approve of a course of action, the medical malpractice case should be dropped. Put in another way, not practicing within the standard of care of the majority is excusable if it can be shown that the respectable minority of physicians practice in the standard of question.[103] If a physician were treating a patient and felt it was time to move on to a more drastic or radical form of treatment, this may open him up to medical malpractice claims if his patient is injured at some point in the process.

However, if a respectable minority of medical professionals supports the line of treatment he prescribed, he may have a valid defence against such claims.[104] However, it should be noted that before beginning such treatments, you must always inform the patient of the potential risks involved..[105]Failing to adequately inform a patient about potential risks can lead to a lack of informed consent claim.[106] Sometimes medical professionals decide to pursue a new or more radical form of treatment in order to effectively treat a patient.

While the decision may place the doctor outside of the medical mainstream, he or she could have a valid defence to a medical malpractice claim if a respectable minority of medical professionals

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[102] Compulsory Treatment and Care for Victim of Gunshots Act 2017, sections 2 (2) (a) (b) and 8

[103] M J Hudson, and G P. Moore, "Defenses to Malpractice: What every Emergency Physician should know" *The Journal of Emergency Medicine* (2011)(41) (6) 598-606

[104] *Ibid* (n9)

[105] *Ibid*

[106] FindLaw,https://www.findlaw.com/injury/medical-malpractice/defenses-to-medical-malpractice-patients-negligence.html(accessed on 19th June 2025).

supports the line of treatment. Of course, the doctor must first inform the patient about the risks involved.[107] In *The State of Board of Medical Examiners v McCroskey*,[108] Dr. McCroskey was under question for making an addendum to a chart after the patient died and making the date of the addendum the date of the death and not the date that the actual addendum was created. It was found that although it is better practice to not back-date notes, there were enough physicians that said he was still within the standard of care.[109]

Exactly how many physicians are needed to create the respectable minority is unclear.[110] This rule could be applied to many clinical situations in which there is not an absolute right or wrong answer. Which antibiotic to choose? Which drug to prescribe?, Who to admit? Who to send home? These are situations in which one group of physicians may do it one way and another group does it another. Not being in the majority group does not mean you are outside the standard of care.[111] For example, it seems that the majority of physicians admit patients with pulmonary embolism to the hospital for anticoagulation. There is a segment of physicians who will manage a low-risk pulmonary embolism patient in the outpatient setting.

If such a patient has an adverse event, they may claim that they should have been admitted to the hospital. Under the respectable minority rule, the physician can claim there are a number of physicians who treat patient's with pulmonary embolism as an outpatient. As long as the physician chooses a 'mode or form of treatment which a reasonable and prudent member of the medical profession would undertake under the same or similar circumstances they shall not be subject to liability for harm caused thereby to the patient'[112]

3.3.7 Two Schools of Thought

This doctrine is applied when there is more than one method of accepted treatment or procedure. A medical practitioner has an

[107] *Ibid*
[108] 880 p. 2d 1188 (Colo. 1994).
[109] *Ibid*
[110] *Ibid* (n 127) at 602
[111] *Ibid* (127) at 603
[112] *Henderson* v *Heyer*-Schulte Corp, Court of Civil Appeals of Texas, 1980. 600 S. W. 2d 844.

absolute defence to a claim of negligence or malpractice when it is determined that the prescribed treatment or procedure has been approved by one group of medical experts even though an alternate school of thought recommends another approach, or it is agreed among experts that alternative treatments and practices are acceptable.[113]

In *Jones v Chidester*,[114]Dr. Chidester performed orthopedic surgery on the leg of Mr. Jones. To obtain a bloodless field, Dr. Chidester used a tourniquet and released it at intermittent times. It was later discovered that Mr. Jones had nerve damage to his leg. Mr. Jones contended that his nerve damage was caused by the use of the tourniquet during surgery. Each side produced evidence and witnesses that supported use of turniquets and avoidance of turniquets.

The jury was instructed that when there are two Schools of thought, it is not the job of the jury to determine which school is more medically appropriate when both schools have their respective and respected advocates. Dr. Chidester was not held liable for exercising his judgement in applying a course of treatment supported by a reputable and respected body of medical experts, even if another body of experts would have performed a different treatment.[115] There is some disagreement as to the critical piece of the two Schools of thought argument that establishes a second school of thought. The disagreement is if a second school of thought requires a 'considerable number' of physicians or does the second school require 'reputable and respected' physicians. Because two schools of thought is a complete defence to malpractice, some feel that it should require both a considerable number as well as reputable and respected physicians, to insure quantity and quality.[116]

An example of 'two schools of thought' would be a patient with cancer who needs chemotherapy with a variety of protocols available. An oncologist may prescribe protocol A with the patient dying. Another physician may have prescribed protocol B with a better result. The primary treating physician would use this doctrine, which advocates that a physician must make their best therapeutic choice, and choosing

[113] *Jones* v *Chidester*, 531 pa. 31; 610. A. 2d 964 (pa. 1992).
[114] *Ibid*
[115] *Ibid*
[116] *Ibid*

the wrong approach on hindsight does not support malpractice. It is clear that in the practice of Emergency Medicine, physicians are frequently faced with making choices that others in the specialty would disagree with on hindsight. This special defence would allow them to advocate their position in court.[117]

3.3.8 Clinical Innovation

Physicians often encounter situations that have no evidence with which to guide clinical practice. They are forced to use their reason and judgment to provide the best care possible. In clinical innovation, the physician is doing something that has little to no historical backing. Clinical innovation is frequently required in daily practice. Physicians must make continuous and constant decisions about their patients with no evidence to guide them. What works at one time may not work another and what works for one patient may not work for the other. Because each clinical situation is unique, the physician may be required to practice clinical innovation.[118]

Clinical innovation, as a defence that is acknowledged by the court, is not to be confused with experimentation, which in the majority of circumstances is not appropriate in the care of patients. Two cases involving the same physician illustrate the difference. In *Felice* v *Valleylab*[119]A surgical resident performed a circumcision using an electrosurgical unit. This was a new technique that was different than using a scalpel, in which she was trained.

Using the electrosurgical unit resulted in burns on the penis that were so severe that the penis had to be amputated. The physician was found to be negligent. In *Tramotin* v *Glass,*[120] the same surgeon again used an electrosurgical unit during breast augmentation surgery. This resulted in burning of the breast of the patient. In this situation, however, the use of electrosurgical unit was not experimental. The physician was not liable for damages. The use of electrosurgical unit on the breast was commonly being done, whereas the use of the device on the penis was not. The physician decided to try the electrosurgical unit on the penis instead of using the available method in which she

[117] *Ibid*
[118] *Ibid*
[119] 520 So. 2d 920 (La. App. 1996).
[120] 668So.2d 1252 (La.App.1996)

was trained (scalpel), and did so without knowledge of the potential risk.

Brook v St. John's Hickey Memorial Hospital[121] also addressed the fine line between experimentation and clinical innovation. In this case, Fischer, a radiologist, injected contrast medium into both of MS. Brook's calves to obtain X-ray studies to help diagnose a urological condition. The contrast medium package insert recommends injections into the buttocks but the radiologist did not discuss his decision to inject into the calf with the parents before injection. At the time of injection, Ms. Brook was only 23 months old.

Four months after the injection, Ms. Brook had shortening of her Achilles tendon. This may have been precipitated by trauma to her ankle or calf muscle. She required two surgeries, wearing of an ankle brace, and other expensive treatment for correction. The package insert did not specifically recommend the calf as an injection site. Dr. Fischer's choice in injection site could be viewed as experimentation. However, during the trial, Dr. Fischer was able to show medical journals and articles that cautioned against the use of contrast medium in the buttocks and thighs of young infants and small children. Dr. Fischer used the calf successfully in other children and had never read or heard that the calf should not be used. He was attempting to avoid damage to the sciatic nerve by using the next largest muscle mass away from the trunk. Through this evidence, Dr. Fischer's actions were viewed as clinical innovation and he was found to not be liable.[122] Documentation is critical any time a provider does something that deviates from the normal standard or is a unique situation. As in the case above, explaining why the standard practice is not being utilised and why the innovative action is necessary is paramount to the defence of clinical innovation.[123]

4. Conclusion

Medical malpractice cases are essentially based on whether or not medical professional violated what is known as the standard of care. This means that the doctor did not provide a level of care consistent with what the regulations demand. Such medical malpractice cases

[121] Supreme Court of Indiana, 1978. 269 Ind. 270, 3880 N E. 2d 72
[122] *Ibid*
[123] *Ibid*

include lack of due care, improper consultation and reference, error in diagnosis, error in treatment or mistreatment, lack of consent to treatment and breach of confidentiality, etc. Physicians are confronted with one form of malpractice or another in their daily practice of medicine. A Physician confronted with medical malpractice has several legal defences to put up. These several defences have been and can be used in defence of malpractice claims, even when it appears that the four elements of duty, breach of duty, harm, and causation are present. They became part of the Nigerian law by virtue of reception of English Laws and not really part of statutory laws like common criminal defences in our Criminal and Penal Codes.

It is therefore recommended that there be a robust Nigerian statutory codifications or recognitions of the defences available to medical practitioners facing medical malpractice claims. An organised legal-medico education training for physicians should be encouraged in order to be fully aware of these defences so that they can optimise and reduce their risk of liability when clinically caring for patients or if confronted with a potential charge of negligence. It concluded that knowledge of these legal defences can help medical practitioners minimise their risk of litigation swhen caring for patients.