LIABILITY FOR DEFECTIVE BLOOD TRANSFUSION IN NIGERIA: LESSONS FROM COMPARATIVE JURISPRUDENCE.*

By

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ABSRACT

The occurrence of transmissible disease arising from the practice of blood transfusion has been on the increase lately due largely to the fact that the practice is uncoordinated as it is unregulated. This paper sets out to examine the common practice of blood transfusion and the probable liability for defective blood transfusion in Nigeria. The paper relied on and drew inspiration from comparative jurisprudence on how to improve service delivery in respect of blood transfusion therapy in Nigeria. The paper revealed that on otherwise innocent and safe health procedure initially adopted to save lives is gradually becoming the reverse of the situation. The paper concluded on the imperativeness of considering the adoption of the strict liability principle to complement the negligence principle as the only applicable principle of liability for resolving medical malpractices cases under the law of torts.

INTRODUCTION

Blood transfusion was previously a rare occurrence in medicinal practice which is fast gaining prominence as a common health procedure in hospitals. Generally, it is supposed to be a safe process employed to save lives and improve the quality of life of patients; however, the reverse seems to be the case now.

Blood in the context of this paper is defined as 'the red liquid that circulates in the arteries and veins of humans and other vertebrate animals, carrying oxygen to and carbon dioxide from the tissues of the body.'[1]Whole blood transfusion involves the transferring of whole blood or blood components from one person (donor) to another (recipient)[2] with the sole aim of improving the quality of life of patients. However, it becomes a paradox that the very fluid transfused with the sole purpose of improving the quality of life has turned out to be a source of danger. A medium through which a range of communicable diseases are been transmitted.[3]The practice of blood transfusion in the country remains largely unregulated and where available such

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[1] 'English Oxford Living Dictionaries', Available at https://www.google.com/search?q=definition+of+blood&ie=utf-8&oe=utf-8&client=firefox-b&gfe_rd=cr&ei=FjnaV9esC8Pv8AfEoJuQDA (accessed on 16 September 2016).

[2]Farlex 'The Free Dictionary', Available at http://medical-dictionary.thefreedictionary.com/transfusion (accessed on 16 September 2016).

[3] Results from a study on transfusion – transmissible infectious agents such as hepatitis B virus (HBV) recently carried out on about 1,410 blood donors, about 406 (28.8%) had serological evidence of infection. See Fiekumo, Igbida, Buseri, Musa Abidemi, Muhibi and Zaccheaus Awortu Jeremiah 'Sero-epidemiology of transfusion-transmissible infectious diseases among blood donors in Osogbo, South-West Nigeria', www.ncbi.nlm.nih.gov/pmc/articles/pmc2782806 (accessed on 16 September 2016).

regulatory and applicable legal framework lag behind what obtain in other jurisdictions.[4] This situation has made it possible for quacks to play significant role in blood transfusion therapy exercise.The instances or circumstances which may result into liability during the course of blood transfusion are many bearing in mind the comatose state of the Nigerian health sector.It is as a result of the above shortcomings that this paper set out to discuss the abovetopic. The paper examined the practice in some common law jurisdictionswith a view to drawing inspirations therefrom toward improving service delivery in this sector. It also makes a case for the adoption of strict liability as an additional theoretical principle of imposing liability in line with the practice in those jurisdictions adopted for comparative discussion in this work.The scope of the paper is generally about liability within the field of tort law. The paper is divided into four major segments comprising of the theories of liability; Nigerian jurisprudence and blood transfusion service; comparative jurisprudence on blood transfusion and lessons learnt; and conclusion and recommendations.

Theories of Liability

In the beginning hospitals were immune from liability arising from the negligent acts of physicians. The rationale for this were many. Hospitals operated like nursing homes, which principally 'housed and fed' those who were sick, while nurses and doctors only ‘rendered medical care.’Trust funds donated to charitable hospitals were not permitted to be deployed to the payment of tort claims;[5]and the payment of such claims were considered a violation of the donors intention which may discourage other donors from making such donations in the future;[6]and in compliance with the implied theory that charity recipients are supposed tohavewaived their right to recover damages bearing in mind that medical services were rendered to them gratuitously.[7]For the above reasons persuasive hospitals were not held accountable for the quality of services provided by them.Overtime, the position changed from what it used to be in the past and hospitals are now held liable for the negligent acts of their staff.[8]

Modern day hospitals are now community health centers providing various health services depending on its status and available facilities.[9]In view of this development

[4] Unlike the practice in Britain, some states in America and South Africa.

[5]Keeton W.P, et al., *Prosser and Keeton on The Law of Torts* 5th ed. (1984) section.133, para 1070.

[6]*Ibid* .

[7] See the cases of *Wilcox v Idaho Falls Latter Days Saints Hosp*. 59 Idaho 350, 82 P.2d 849 (1938); *St Vincent’s Hosp v Stine* 195 Ind. 350, 144 N.E. 537 and *Forrest v Red Cross Hosp,* 265 S.W. 2d 80 (KY. 1954)

[8] See the case *Bing* v *Thunig*, 2 N.Y. 2d 656, 666 where the court observed as follows: ‘Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such service, if necessary by legal action.’

[9] See *Ybarra v Spangard*, 25 Cal. 2d 486, 491, 154 P.2d 687, 691 (1994). The modern hospital has become a community health center designed to provide patient care of the highest quality. See also the case of *Moore v Board of Trustees of Carson –Tahoe Hosp.,* 88 Nev. 207, 211, 495 P.2d 605 (1972). Finally, in this regard see Angel, ‘Professionals Unionization,’ (1982) 66 MINN. L. REV. 383. 411-12 where the writer observed that: “Recent developments in the health care industry have derogated the

courts have re-evaluated the traditional legal basis of holding hospitals culpable for medical malpractice by evolving new theories to justify hospital liability. These theories of liability have a long history under tort law; but their applications as basis of grounding liability in cases of medical malpractice are quite novel and recent.

The practice of whether to hold hospitals liable for medical malpractice arising from blood transfusion varies from jurisdiction to jurisdiction. In some jurisdictions, blood banks or hospitals have been granted an 'across the board charitable immunity',[10]while in someother instances courts have concluded that no sale of the blood took place, thereby excluding such transaction out of the field of warranty. There are other instances where courts have ruled that liability should not be imposed ifthere is no test in existence to determine the existence of the infection alleged to have been transmitted.[11]

Liability is defined as '...quality or state of being legally obligated or accountable; legal responsibility to another or to society, enforceable by civil remedy or criminal punishment....'[12]In resolving medical malpractice cases in respect of blood transfusion therapy, Nigerian courts adopts the negligence principle, while courts inother jurisdictions forming the basis of our comparative discussion in this work complement the negligence regime with the strict liability principle.

Negligence

Negligence is defined as'the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; any conduct which falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or willfully disregardful of others' rights.'[13]

The evolution of negligence as a theoretical principle of liability under tort law was not spontaneous; it was a gradual exercise which evolved over a considerable period.[14]For a tortfeasor to be found culpable under the negligence regime the

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role of the individual practitioner, while promoting the growth and expansion of hospitals. As health care became hospital-based, and the number of medical specialties...increased, hospitals changed from small, local, charitable institutions to major industries."

[10] See George Newman 'Liability for Blood Transfusion Resulting in Serum Hepatitis' 12 WM &*Mary L.R.* 86 (1970).

[11]*Ibid* at 86

[12] Black's Law Dictionary 7thed. See also the following cases: *Okwejiminor v Gbakeji* (2008) ALL FWLR Part 409 at 442-443 para G-H, *Blyth v Birmingham Waterworks Co.* (1856) 11 Exch. 781; *Lochgelly Iron and Coal Co. v M'Mullan*(1934) AC 1. Negligence was defined as '...the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs would do or doing something which a prudent and reasonable man would not do.'

[13] Black's Law Dictionary 7thed. See the following cases: *Okwejiminor v Gbakeji* (*Supra), Blyth v Birmingham Waterworks Co.* (*supra*); *Lochgelly Iron and Coal Co. v M'Mullan* (*supra*).

[14] See the following cases: *Dixon v Bell* (1816) 5 M&S 198, *Langridge v Levy* (1837) 2 M&W 519, *Winterbottom v Wright* (1842) 10 M&W, 109. *Heaven v Pender* (1883) II Q BD 503,*Donoghue v Stevenson* 1932 A.C. p. 32, *Cambridge Water Corporation v Eastern Countries Leather Plc*(1994), HL 768.

following constituent elements must be established: duty of care, breach of duty, causation and damage caused by the breach.[15]

Strict Liability

Strict liability is defined as 'liability that does not depend on actual negligence or intent to harm, but that is based on the breach of an absolute duty to make something safe.'[16]Strict liability as a theoretical principle of liability under common law evolved in the case of *Ryland v Fletcher.*[17] Over time, this principle was extended to some categories of torts. Presently in Nigeria, strict liability is not adopted as a theoretical principle of resolving blood transfusion cases unlike the position in some states in America; South Africa and the United Kingdom.[18]

The rationale for holding a hospital liable on any of the above theoretical principles of liability can be premised on the following principles of law: *respondeat superior* principle, ostensible agency, or corporate liability principle.

Respondeat Superior

The respondeat superior principle is to the effect that an employer is held liable for the tortious act of his employee committed within the scope of his employment.[19] This in common law jurisdictions is referred to as the doctrine of vicarious liability. The legal analysis behind this principle is whether the master had the right to control the servants activities at the time the act complained of happened.[20]Once it is established that the master had the right to control the servants; then it will be unfair to permit a patient who had suffered as a result of the negligence of the servant to go uncompensated. Patients seek medical attention with the hope of receiving treatment which will improve their physical and mental conditions while expecting some degree of control from the hospitals management.

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[15] See the case of: *Okins Biscuits Ltd v Oshe* (2004) FWLR (Pt. 188) 494 C.A. See also *Okwejiminor v Gbakeji* (*Supra*)

[16] Black's Law Dictionary 7thed.

[17](1866) L.R.I. Exch. 265. The principle of strict liability connote that a tortfeasor is liable for the damages or loss arising from his act despite the absence of fault from him. The origin of this principle is traceable to the decision of Blackburn J. in the case of *Ryland* v *Fletcher* [1866] L.R. 1Exch 265, 279-280. In this case, the defendant was sued by the plaintiff for damages occasioned to its mine caused by escape of water from the defendant's reservoir. The trial court found the defendant not culpable as there was no negligence on their part concerning the selection of the site; coupled with the fact that they had no knowledge of the underground shaft connected with the plaintiff's land. The plaintiff was dissatisfied with the decision and appealed to the court of Exchequer Chamber where the defendant was held culpable. *Blackburn J* propounded the strict liability principle as follows:'…that the person who, for his own purpose, brings on his land and collects and keeps there anything likely to do mischief if it escapes, must keep it in at his peril, and, if he does not do so, he is prima facie answerable for all the damage which is the natural consequence of its escape…'

[18] See the following provisions – *Restatement 2d* S.402 of Torts, S.61 Consumer Protection Act of South Africa, S.2 (1) Consumer Protection Act 1968 (UK).

[19] See the case of *Bing* v *Thunig, (Supra)* at 666 where the court observed that liability can be avoided if the hospital can establish that the negligent party was not his employee.

[20] See Swan, 'Hospital Liability for Corporate Negligence' 1984 *MED. TRIAL TECH. Q*. 275, 276.

Ostensible Agency and Corporate Liability

Liability can also be imposed on a hospital based on ostensible agency and corporate liability rule. Though both theories examine liability issues from different angles, but the result remain the same.[21]

i. Ostensible Agency

Ostensible agency liability is a type of vicarious liability under which a health care facility may be held liable for a healthcare provider's negligence. This occurs where a principal wrongly leads a third party into believing that another is the principal's agent. The third party however must establish the following elements before recovery can be made against the principal for the ostensible agent's negligence; the third party dealing with the agent must reasonably believe in the agent's authority;[22] the act of the principal or omission must have led to such belief;[23] and the third party who relied on the agent's authority must not be careless or negligent.[24]

Typical of this instance is where a principal's action would reasonably lead a third person that an agency exists. It must however be noted that if a patient has notice that an employer – employee relationship does not exist, then such patient cannot rely on the ostensible agency relationship to hold the hospital liable.

ii. Corporate liability

This theory is founded on the notion that a hospital owes duty directly to its patient on the basis of the fact that there is a direct obligation on the hospital to provide quality medical care and to also protect its patient's safety.[25] Any breach in respect of the above obligation on the part of any of the hospital's personnel leads to corporate or hospital liability since patients are entitled to expect quality treatment from hospitals

[21] The theories as they exist in one of the jurisdictions in America were described as follows: 'Hospital liability may arise only where it can be established that the negligent physician was either an employee of the hospital or appeared to be an agent of the hospital. If, however, the physician is not an employee of the hospital, but merely has staff privileges and an apparent agency relationship cannot be established, such physician may be treated as an independent contractor and the hospital will not be held liable for his negligence. Thus, the current focus in California is upon the nature of the hospital's relationship to the physician rather than upon the nature of the hospital's role in providing competent medical treatment. The corporate negligence theory...would appear to focus upon the hospital's role in the overall scheme of patient care, placing accountability upon the hospital commensurate with that role.'

[22] See Payne, 'Recent Developments Affecting a Hospital's Liability for Negligence of Physicians,' 18 *S. TEX. L.J.* 389, 399.

[23] See *Revitzer v Trenton Medical center,* Inc., 118 Mich App. 169, 175, 324 N.W. 2d 561 (1982), in this case, the court held that defendant did not act in such a way as to create an agency by estoppel. The Revitzer court found that the 'plaintiff viewed defendant's medical facility as the situs where her physician would treat her, and the fact that (the physician's) office was situated in a medical facility was inconsequential to plaintiff's selection of him as her physician.' The court held, therefore, that the plaintiff had not been misled into believing that the hospital was offering her independent benefits.

[24]Payne (n 22) 389, 399.

[25] The Washington Supreme Court adopted the theory of corporate negligence in *Pedroza v Bryant,* 101 Wash 2d 226, 677 P.2d 166 (1984). The principal issue which came up for resolution in Pedroza was whether a hospital could be held liable under the theory of corporate negligence for its action in granting staff privileges to a non-employee physician who allegedly committed malpractice while in private practice off the hospital premises. The court held that the theory is limited to individuals who are treated as patients within the hospital.

based on the sophisticated equipments and highly trained personnel in their employment.[26]

Nigerian Jurisprudence and Blood Transfusion Therapy.

Practice and Regulatory Framework.

Currently, there is no single legal regime regulating or guiding blood transfusion therapy in Nigeria. Recourse for this is had to related legal provisions guiding medical malpractice in Nigeria. This is however without prejudice to the fact that there are some administrative rules which sincerely lacked legal backing and are more honoured in breach. This situation has made blood banking and transfusion services in Nigeria to be fragmented, uncoordinated and unregulated thereby making the practice a free market for all. Little wonder why there are many blood banks located at different parts of the country without adequate supervision. This situation has contributed significantly to the high incidence of transfusion related infection in Nigeria, such as Human Immunodeficiency Virus otherwise referred to as(HIV),[27] which if left untreated leads to Acquired Immune Deficiency Syndrome which is a disease.

To improve the safety of blood transfusion therapy in Nigeria and stem down the tide of transmissible diseases contracted through blood transfusion, there is in existence a National Blood Transfusion Service (NBTS) policy. This policy was a product of a baseline survey conducted sometimes in August 2005.[28]The National Blood Policy couldbest be described as mere expression of ideal desires since the administrative mechanism through which body came into existencedoes not empower it to regulate blood transfusion in the country. More importantly, there is no supporting or enabling enactment which prescribed how blood can be acquired, stored, dispensed and administered, thoughthere are in existence ethical standards and guidelines provided by the World Health Organization[29] directed towards ensuring safety in blood transfusion therapy. However, howeverthese standards and guidelines are not followed.

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[26] See *Johnson v Misericordia Community Hosp*. 99 Wis. 2d 708, 724, 301 N.W. 2d 156, 164 (1981). This case demonstrates the importance of hospitals screening the qualifications of physician/ applicants. The case arose out of an operation performed at Misericordia by Dr. Salinsky. The doctor unsuccessfully attempted to remove a pin fragment from plaintiff's hip. While performing the operation a nerve and an artery were damaged, and this caused permanent paralysis of plaintiff's left thigh muscles. The jury returned a verdict for the plaintiff, apportioning 20% of the causal negligence to the doctor and 80% to the hospital.

[27] Federal Ministry of Health 'National Blood Transfusion Service', available at http://www.nbts.gov.ng (accessed on 16 September 2016).

[28] Federal Ministry of Health 'National Blood Transfusion Service', available at http://www.mamaye.org/en/evidence/national-blood-policy-nigeria (accessed on 16 September 2016).

[29]World Health Organization 'Safe Blood and Blood Product Guidelines and Principles for Safe Blood Transfusion Practice', available at www.who.int/bloodsafety/transfusion_services/introductory_module.pdf (accessed on 16 September 2016).

While not unmindful that public health is administered by the government, the private sector accounts for 70% of all the health facilities in the country.[30] Some of these private facilities have no standard which ensures safety in blood transfusion therapy. Adequate facilities are lacking, budgetary allocation to this sector continues to dwindle because of the economic reality of the nation whileadequate personnel are not available in some sector.

This has greatly affected the quality of services rendered by practitioners in the field of medicine, which indirectly has impact on blood transfusion services.Private and Public hospitals delegate transfusion process to nurses under their supervision since doctors are mostly overwhelm with other heath-giving assignments. Haemovigillance which is a risk monitoring system forming part of blood transfusion therapy is equally lacking because comprehensive records are not taken during blood transfusion therapy.

Applicable Legal Regime

It is an incontrovertible fact thatthere is no national legislation regulating blood transfusion services in Nigeria. Recourse is had to the provisions regulating medical practice in the country and some other related provisions which indirectly have effect on blood transfusion service. These provisions are *Medical and Dental Practitioners Act*, which shall hereinafter be referred to as the 'Act',[31]*Medical Code Ethics in blood Transfusion,*[32]*National guidelines for blood transfusion*[33] and the principles of common law in Tort.

The 'Act' amongst a host of duties empowers the body to make rules of professional standards and code of medical ethics for medical practitioners in Nigeria and to establish Disciplinary Tribunals and Investigating Panels for the enforcement of these rules. It further stipulates the qualification to be possessed before one can practice as a Physician or Dental Surgeon in Nigeria. The *Code of Medical Ethics* also provide guidelines in respect of blood transfusion services. It follows from the above statutory provision that medical practitioners engaged in transfusion therapy are statutorily responsible for patients care under their supervision while any breach of the duty of care will ground an allegation of medical negligence.

[30]Federal Ministry of Health. Operational Guidelines for Blood Transfusion Practice in Nigeria NBTS 2007.

[31] Cap M8 Laws of the Federation of Nigeria 2004. This provision empowers the Medical and Dental Council of Nigeria to make rules of professional standards and code of medical ethics for Medical Practitioners in Nigeria. It also empowered the Council to established disciplinary tribunal and investigating panel.

[32]Maharashtra State Blood Transfusion Council 'Ethics in Transfusion Service' available at http://www.mahasbtc.com/ethics-transfusion-service, (accessed on 16 May 2016).

[33] World Health organization 'Safe Blood and Blood Product Guidelines and Principles for Safe Blood Transfusion Practice', available at http://www.who.int/bloodsafety/transfusion_services/Introductory_module.pdf, (accessed on 16 May 2016).

Negligence Theory and Liability for Blood Transfusion

Negligence theoryis the only theoretical principle of liability of resolving blood transfusion malpractice in Nigeria. Bearing in mind the dearth of Nigerian cases in this segment of the law (blood transfusion) references will be made to decisions from other common law jurisdictions for comparative evaluation.

That renowned English writer, Sir William Blackstone in his *Commentaries on the Law of England* in 1768 coined the term *'mala praxis'* which refers to injuries caused to a patient while undergoing medical treatment due to professional neglect or lack of skill. Within the context of Nigerian jurisprudence, malpractice is defined by the *Code Ethics of Medical Ethics* as:'….that act by a registered practitioner for whom he or she is found guilty by the statutory procedure, to have failed to meet the professionally accepted standards, method or decorum in any area of professional practice'.[34]

In the case of *Huck v Cole*[35] Lord Denning MR while considering the circumstances under which a medical practitioner could be held culpable under a medical malpractice action ruled that to hold a medical practitioner culpable in negligence his conduct should be deserving of censure or it should be inexcusable.
Finally, on this issue, in the case of *Bolam v Friern Barnet Management Committee*[36]the court noted that 'A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.' An injury arising during blood transfusion therapy qualifies as medical malpractice.

Implicit in the above definitions of medical malpracticeis what is often referred to as the negligence standard. To ground liability under the negligence regime the following constituent elements must be established: duty, breach of duty and damages caused by the breach. An examination of these constituent elements in relation to medical malpractice arising from blood transfusion therapy will now be discussed.

Existence of a Duty Relation

The first element necessary to establish the liability of adefendant in respect of alleged medical malpractice case founded on negligence arising during blood transfusion therapy is to establish the existence of duty or a duty relation.[37]

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[34] See generallyMedical and Dental Practitioners in Nigeria 'Mode of Medical Ethics in Nigeria' http://www.mdcnigeria.org/Downloads/CODE%20OF%20CONDUCTS.pdf (last accessed last on 16 September 2016)
[35] (1993) 4 Med LR 393
[36](1957) 1 WLR 583.
[37] See Winfield, *Duty in Tortious Negligence* (1934) 34 Col. L.R. 41 at 43, where he opined that duty is 'a restriction of the defendant's freedom of conduct; and the particular restriction here is that of behaving as a reasonably careful man behave in similar circumstances'. See also Morrison, 'A Re-examination of the duty of care' (1948) 11 *Mod .L. R.* 9, who described duty as follows: 'By duty situation is meant a situation described by reference to the particular characters and relations of the parties involved in it, recognized by the courts as giving rise to a legal duty to take care. Such, for example, are the duty situations of occupiers and invitee, manufacturer or repairer of chattels and the

The development and recognition of a duty relation has long confronted the courts.[38] The recognition of a duty relation under tort law grew gradually through case law spanning several years[39] until on or around 1932 when it became firmly recognized. This was the year the landmark decision in the case of*Donoghue v Stevenson*was delivered[40]and the 'neighbourhood'principle propounded by *Lord Atkin*[41]was formulated.

Lord Atkin's statement in 'the *Donoghue's*case'[42] does not fully capture the groups or categories of those who owe the duty of care or those who could be held potentially liable. However, it is not in doubt that a physician or hospital blood bank personnel/staff saddled with the responsibility of transfusing blood to a patient owed such a patient a duty of care. The moment a patient is enrolled in the hospital, a duty of care is owedto him. This proposition is supported by the provisions of*Rule 28* of the*Code of Medical Ethics.* This provision is to the effect that a duty of care is owed by medical practitioners to their patients. This impliedly includes medical practitioners who engaged in blood transfusion therapy.[43]

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user of the chattels. It is a short method of referring with some particularity and correctness to the specific set of concrete circumstances giving rise to the duty of care in the individual case'.

[38] See Leone Green, 'The Duty Problem in Negligence' (1928) 28 *Col. L.R.* 41 remarked as follows: 'How does the stating of the problems in terms of duties enable a Judge to pass judgment? Where shall he find the source of duties? Do Judges find them ready made, and if so, do they create them in wholesale or must each court create a particular duty which fits the particular case before it? So far I have been able to discover that common law courts have stumbled through the whole period in their existence without committing themselves on this inquiry'.

[39] See the following cases: *Heaven v Pender (supra), Dixon v Bell* (*supra), Langridge v Levy* (*supra)* and *Winterbottom v Wright (supra).*

[40] 1932 AC 562

[41] The principle formulated in the case is to the effect that: 'The liability for negligence...is no doubt placed upon a general public sentiment of moral wrongdoing for which the offender must pay. But acts or omissions which any moral code would censure cannot in a practical world be treated so as to give a right to every person injured by them to demand relief. In this way rules of law arise which limit the range of complainants and the extent of their remedy. The rule that you are to love your neighbour becomes in law - you must not injure your neighbour; and the lawyer's question, who is my neighbour? Receives a restricted reply. You must take reasonable care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law, is my neighbour? The answer seems to be – persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question.'

[42]*Supra* at 569.

[43]'Medical practitioners and dental surgeons owe a duty of care to their patients in every professional relationship. The particular skill which training and eventual recognition and registration bestow on a practitioner, is to be exercised in a manner expected of any practitioner or any other member of the professions of his experience and status. It is required that a practitioner upgrades his skill as best as possible in the light of advancing knowledge in the profession. To this end, regular participation in programmes of continuing medical education is a necessary condition for the practitioner to remain relevant in practice and to achieve renewal of his practicing license based on the guidelines that are released by the Council from time to time. A practitioner must see and attend to all patients on admission under his care, as frequently as their conditions demand. In an emergency, for instance at the scene of a road traffic accident, a doctor passing by is under no inherent duty to stop and render first aid to the victims; but if he decides to stop and render care, he is bound by the ethics to exercise a degree of reasonable care, that is, to do everything that a competent and reasonable registered practitioner would do in the circumstance. In Nigeria there are, outside the control of medicine and dentistry, peculiar social problems which create obstacles to the full manifestation of the degree of skill

In the Nigerian case of *Abatan v Awudu*,[44] the court observed that: 'the relationship between a doctor and his patient is one of trust and confidence; a relationship where one has the power and duty to treat and restore the other to mental and physical well-being.'The doctor-patient fiduciary duty relationship is the foundation of the duty of care owed to any patient. Also in the Indian case of *Dr. Laxman Balkrishna Joshi v States of U.P*,[45] the court laid down the following as obligations owed by a medical practitioner once he is consulted.These are: duty of care in deciding whether to undertake the case, duty of care in deciding what treatment to give, and duty of care in the administration of that treatment. A breach of any of the above obligations may give rise to an action in negligence.

Breach of Duty

The second constituent element under the negligence regime necessary to establish the culpability of a service provider or doctor in respect of blood transfusiontherapy is breach of the duty of care.

The standard of the "reasonable man" or the famous "man on the Clapham omnibus" who is said to be an ordinary person placed in the same circumstances is usually applied for most tort cases. Where however there is a potential breach of professional duty this is re-interpreted as the standard of comparable professional practice. The standard of care required in an action against a hospital for alleged injury arising from blood transfusion has been described as "...reasonable measure of safety and blood testing exercised by like and similarly situated facilities..."[46] Where the injury sustained by a claimant can be traced to other sources the hospital management or practitioner will not be held liable.

In *Bolam v Friern Hospital Trust*[47] a patient who sustained fractures during ECT treatment, filed a medical malpractice action alleging negligence. He contended that he was not given anesthesia for muscle relaxation when he was treated. Further that he was not restrained or warned of the risks of fracture. The court held that negligence was not established because evidence was adduced that at the material time when the operation was carried out, it was not a universal practice to administer muscle relaxation. Contrasting opinions were given in this regard at trial as to the benefits of muscle relaxation balanced against the increased risks of the relaxant. The court ruled that that if a doctor acted in accordance with a practice that was considered acceptable

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that is expected; this situation does not preclude the practitioner from acting within the degree of reasonable care that is possible under the circumstances. Thus, a registered practitioner who fails to exercise the skill or act with the degree of care expected of his experience and status in the process of attending to a patient is liable for professional negligence.'

[44](2003) 10 NWLR (Pt. 829) 451 CA.

[45] AIR 1969 SC 128

[46] Townsend and Stockton, 'Liability of Hospitals and staff for blood banks, infection and Pharmacy Error,' available at http://www.kupatricktownsend.com/en/Knowledgeenter/publications/Articles/1999/11/LiabilityofHospitalandStaffforBloodBanksInfectionControlandPharmacyErrors.aspx (accessed on 19 June 016).

[47]*Bolam v Friern Hospital Management Committee* (*supra*)

by a responsible body of doctors, that was sufficient and the claimant must show that no reasonable doctor acting in the same circumstances would have acted in that way.[48] Bearing in mind that progress in medical knowledge takes some time before information are disseminated, coupled with the fact that not every change can be immediately put into practice, a medical practitioner will not be held culpable if he fails to adopt new developments which he was yet to be acquainted with.[49] Errors of judgment do not automatically translate to breach of duty, except where the service provider has not acted with a level of care that would be expected from a reasonably competent professional. The situation in which a doctor's negligent practice is judged by the standard expected from the doctor's peers is generally known as the *'Bolam standard'*. This standard emanated from the case of *Bolam v Friern Hospital Management Committee.*[50]

The circumstances under which such breach may occur are many; and may includeany of the following: failure to secure the consent of the patient or transfusing a patient withmismatched blood. If a patient withholds or withdraws his consent of being transfused with blood, the medical practitioner must stay action, failing which he would be held liable for the tort of battery/ assault; even if the transfusion is beneficial to the patient.[51] However in the case of *Tegan Esabunor v Faweya*[52], a medical practitioner who acted pursuant to the order of court was sued for transfusing blood to an under-aged whose mother a Jehovah witness earlier objected to the procedure. The practitioner was exculpated from liability having acted pursuant to order of court.[53]

Causation and Remoteness of damage

Causation is defined as the causing or producing of an effect.[54] There is an obligation on the part of the patient to establish that thebreach of duty alleged arose during blood transfusion therapy. In this regard, the patient must establish a causative link between

[48] See also the case of *Fischer v Wilmington General Hospital*, 51 Del. 554, 149 A. 2d 749 (Super. Ct.1959). In this case, the claimant, a patient received a whole blood transfusion and contracted serum hepatitis. She alleged negligence on the part of the hospital on the following grounds: allowing its agents to administer the transfusion using blood containing the serum hepatitis virus and also failure to advise her of the possible danger of serum hepatitis in blood transfusion. The court observed as follows, '[d]efendant's affidavits establish indisputably that there is no known medical technique by which the virus which causes hepatitis can be detected or destroyed in whole blood.' The court further observed that '... the issue ... would appear to be whether the known risk here involved was of a type which imposed upon the defendant a duty to warn the plaintiff in advance.' The court held that the hospital was not negligent in performing the transfusion or in failing to warn the patient of the possible risks involved.

[49] See *Crawford v Board of Governors of Charing Cross Hospital, The Times,* 8th December 1953.

[50]*Supra*.

[51] See the case of *Sideaway v Board of Governors of the Bethlem Royal Hospital* (1985) UKHL 1 (21 February 1985): (1985) 1 All ER 643, (1985) AC 871.

[52]2008 12 NWLR (Pt 1102) 794 C.A

[53] See also the case of *Dr Okezie v Chairman Medical and Dental Practitioners Disciplinary Tribunal* CA/L/206/200, a case in which the decision of the Medical and Dental Council Tribunal which found the defendant culpable for failing to provide cross-matched blood as a result of post-operative complication was set aside on appeal by the court on other grounds.

[54] Black's Law Dictionary 7thed.

the breach of duty and the injury suffered or occasioned tohim under the negligence regime. Failure to establish a causative link will result to the dismissal of the claim. To establish causation in a blood transfusion case, recourse is had to the relevant rules of tort. Causation within the context of this work will only be examined in terms of factual causation. The essence of this enquiry is to establish a link between the damage occasioned to the prejudiced party and the practitioner's negligence or supply of defective blood.

The standard of proof required in this regard is based on balance of probabilities.[55] Establishing a causal link between resulting injury and the transfused blood at times may prove difficult, time consuming and may also entail the consideration of complex scientific evidence.[56] There are however other instances, when an inference of negligence may be drawn easily.[57] In establishing a causal link between the injury and ensuing damage the *'but for'* test is the principal test adopted in medical malpractice cases which blood transfusion is a segment. This test is to the effect that if not for the defendant's breach of duty or supply of defective blood the harm suffered by the claimant would not have occurred.

This test was adopted in the case of *Barnet* v *Chelsea and Kessington Hospital Management Committee.*[58]In this case, the cause of death of the claimant's husband was associated to arsenic poisoning which had no connection to the delay of the hospital in attending to him; consequently, the hospital was held not culpable for his death.

The principle of *res ipsa loquitur* 'which literarily means "the thing speaks for itself" may also assist in establishing causation in medical malpractices cases depending on the circumstances of the events which led to the injury. Typical of such an instance is where a swab or a small scissors is left in the stomach of a patient who had undergone an operation. If such a patient dies, the principle may come into play as basis of justifying that the tortfeasor caused the deceased death.

It must be noted that for patients to establish causation in respect of negligent acts committed by service providers during blood transfusion therapy or for medical malpractice cases in general is a very difficult task. Most patients lack the financial

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[55] For instance, in the case of *Vadera*v *Shaw* (1999) 45 BMLR 162, CA, the plaintiff a 22-year-old Asian suffered a brain stem stroke having been prescribed 'Logynon' by her doctor. She commenced an action against the doctor. The decision of the trial court was to the effect that it could not be established applying statistics to the available figures that the association between the oral contraceptive and stroke was more than a relationship of chance was upheld on appeal. In the circumstances of the case, the plaintiff had failed to prove causation on balance of probabilities.

[56] See the case of *Ashington Piggeries* v *Christopher Hill Ltd,* (1972) AC 441 and *XYZ & Others* v *Schering Health Care Ltd* (2002) EWHC 1420 (QB).

[57]For instance, where a wrong blood group was transfused to a patient.

[58](1968) 1 All E.R. 1068. See also the cases of *Robbinson* v *Post Office* [1974] 2AII ER 737, *Vernon* v *Bloomsbury Health Authority* [1995] 6 Med LR 297.See further the following cases on the application and limitation of the but for test: *Belitho v City and Hackney Area Health Authority* [1988] AC 232, *Hodgson v Imperial Tobacco Ltd* (Lexis Transcript 9 January 1999) and *McWilliams* v *Sir Arrol& Co* [1962] 1 All ER 623.

will to procure expert evidence. Also witnesses who mostly are colleagues of the tortfeasors are at times unwilling or not ready to do so.

The above represent the position of the law in Nigeria in respect of medical negligence *viz a viz* blood transfusion therapy. Issues concerning recoverable damages and applicable defenses will be discussed in this paper presently.

Comparative Jurisprudence: Practice, Regulatory and Theoretical Principle of Liability

Practice and Regulatory Framework

In the United Kingdom and United States of America, the practice of blood transfusion is coordinated and well monitored unlike the free market for all enterprise operating in Nigeria. In those foreign jurisdictions, there is in existence adequate safety mechanism to reduce to the barest minimum incidences of transmissible diseases arising from this practice. The provisions of applicable ethical codes and existing statutory guidelines are followed. For instance, in the United Kingdom there is in existence the Royal College of Nursing Guidelines formulated to improve blood transfusion therapy and practice.[59] The provision of this guideline is adhered to and adequately monitored to identify areas of lapses with the aim of remedying such. This guideline sets out pragmatic advice for nurses engaged in the service of blood transfusion. In addition to this, there is also in existence the European Union Directive 2005/62/EC.[60] This document makes it mandatory that all staff to be engaged in this sector of medicinal practice must be trained. The provision of the above Directive has been domesticated in the UK.[61] These provisions set out standards ofquality and safety for the collection, testing, processing storage and distribution of human blood components.[62]In summary from the various applicable legislative and regulatory documents, practitioners are expected to ensure that the following steps are taken: that only trained staff should engage in transfusion exercise; valid consent must be obtained before transfusion is commenced; full information about the proposed treatment must be given to the patient; patient being transfused with blood must wear identification tag; when blood sample is to be taken, detailed information concerning the patient first name, and date of birth must be taken to ensure that the right patient is before the service provider, and where the patient is unconscious a relative should be asked to confirm theseinformation; the patient's identity, and case file must be examined and compliance with all guidelines must be met before transfusion and

[59] Royal College of Nursing 'Right Blood, Right Patient, Right Time', available at https://www.google.com/search?q=Royal+college+of+nursing+guideline+on+blood+transfussion+in+uk&ie=utf-8&oe=utf-8&client=firefox-b-ab&gfe_rd=cr&ei=rqhTV-bIDIrW8Af60qOgCQ. (accessed on 16 May 2016).

[60] See European Commission 'EU Legislation on Blood & Blood Components', available at http://www.ab.gov.tr/tarama/tarama_files/28/SC28EXP_Blood.pdf (accessed on 16 May 2016).

[61] See also National Patient Safety Agency (NPSA) Safer Practice Notice (SPN) 14 (2006) and NH SQ Quality Improvement Scotland (NHSQ 15) Clinical Standards for blood transfusion (2006).

[62]See Blood Safety and Quality Regulations 2005 (Statutory Instrument 2005/1098).

finally if any discrepancies is observed, it is advisable that the practitioner to do not proceed with transfusion.[63]

Notwithstanding the existence of these safety mechanism and initiatives, transfusion error continues to occur in the United Kingdom and United States of America.

Theoretical Principle of Liability

Negligence and strict liability principles are the two theoretical principles of liability adopted in the two jurisdictions forming the basis of our comparative discussion in this paper. The position on the negligence regime as it pertains to the constituent elements of duty, breach and causation in Nigeria is substantially the same with the position in the United Kingdom and the some of the states in the United States of America. Consequently, these constituent elements will not be repeated or discussedunder this segment in orderto avoid repetition.

Strict Liability

Strict liability as a theoretical principle of liability owes its origin to the English case of *Rylands v Fletcher*;[64] this principle is also recognized under American law. The principle of strict liability for defective product was first applied in the United States by the Supreme Court of California in the case of *Greenman v Yuba Power Product Inc.*[65]The Thalidomide incident of 1961 served as the impetus for the adoption of strict liability principle as an additional theoretical principle of liability in resolving product liability claims under English Law. This incident led to a reform of product liability law in Europe which culminated into the adoption of European Community (EC) Directive on Liability for Defective Products' that was adopted on 25th July 1985.

The Directive introduced the concept of strict liability (liability without fault) on the part of the producer as stated in its *Article 1*.The United Kingdom was the first country to implement the Directive by promulgating the Consumer Protection Act of 1987 (CPA) which introduced strict liability as an additional principle to resolve product liability claims.[66]In the United States, the provision of section 402 of *Restatement Second of Torts* contains the provision relating to strict liability as it relates to defective products.[67]

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[63] See generally BSCH 2009. BCSH 2012b and UK Blood Safety Quality Regulations 2005.
[64]*Supra* n 17.
[65] (1963) 377 P.2d 697
[66] See Section 2(1) of the Consumer Protection Act 1987
[67] (i). Provisions of Section 402A Restatement 2d.

(a) Section 402A. Special Liability of Seller of Product for Physical Harm to User or Consumer

(1) 'One who sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm, thereby caused to the ultimate user or consumer, or to his property, if

(a) the seller is engaged in the business of selling such a product, and

(b) it is expected to and does reach the user or consumer without substantial change in the condition in which it is sold; and

Unlike the position under the negligence regime, there is no enquiry into the conduct of the tortfeasor, rather the defectiveness of the product which in this case is blood, is the focus.

United Kingdom's position

The following elements must be established before a blood transfusion service provider can be held liable under the strict liability regime in the United Kingdom; these are defectiveness of the blood; causal link between the defectiveness and ensuing damage and damages. These elements will now be considered.

Ascertaining the Defectiveness of Blood (UK Perspective)

One of the earliest cases in which the provisions of the Consumer Protection Act on defectiveness or otherwise of bloodwas considered was the case of *A & others v The National Blood Authority.*[68] This case involved a group action initiated by 114 individuals who had all contracted the Hepatitis C virus as a result of blood transfusion prior to the introduction of screening tests in the United Kingdom in September 1991. It was not in dispute that the risk of *non-A, non-B Hepatitis* ('NANBH') had been known since the 1970's; while the *hepatitis C* virus was not identified until spring 1988.

The two principal issues contested in the case were whether the blood transfused to the claimants was defective and if so, whether the defendant could plead the development risk defence in other to relieve them of liability. In resolving the case, notwithstanding the differences in the phraseology of the 'CPA' and the 'Directive' on the issue of defectiveness *Burton J* referred mostly to the provisions of the Directive during his judgment.

The provision of the Directive concerning defectiveness or otherwise of a product is contained in Article 6(1) of the 'EEC' Directive which is to the effect that

> [a] product is defective when it does not provide the safety which a person is entitled to expect, taking all circumstances into account. A reflection on this provision reveals that it is couched in terms of consumer expectation unlike the 'reasonableness' standard of the negligence regime.

The defendant in this case contended that the relevant test was as to 'the conduct that a consumer could reasonably expect of the producer in ensuring safety of the product.' The claimants however argued that the relevant test was 'the legitimate expectation of the public in relation to the safety or not of the product in question.'

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(2) The rule stated above applies although (a) the seller has exercised all possible care in the preparation and sale of his product, and (b) the user or consumer has not bought the product from or entered into any contractual relation with the seller'.

[68](2001) 3 All ER, 298. For discussion of the question of natural products, such as biological ones constituting products under the Directive, see Grugg, A and Pearl, D. S. *Blood Testing, Aids and DNA Profiling* Bristol, Family Law, (Jordan & Sons Ltd 1990), 135-42.

On these arguments Burton J concluded and stated as follows: 'I do not consider that the legitimate expectation of the public at large is that legitimately expectable tests will have been carried out or precautions adopted. Their legitimate expectation is as to safeness of the product (or not)'.[69]

The questionis how one ascertains the legitimate expectation of the consumer. In doing this, the learned trial judge introduced a distinction between 'standard and non-standard products.'He rejected the traditional categories of defects on the ground that it does not capture some defects which may have been caused as a result of shortcomings in the design of a manufacturing process.[70]He proceeded to classify products into 'standard and non-standard' products which he adopted as the major index or parameter to ascertain defectiveness or otherwise of a blood product. The first-reason for this classification was to identify the harmful characteristics which caused the defect, and in this case, it was the harmful characteristic, *'the Hepatitis C virus.'*

The second reason was to ascertain whether the product in question, i.e. the blood was a 'standard or non-standard product'.

In this respect he defined 'standard and non-standard' products as follows:

> ...a standard product is one which is and performs as the producer intends. A non-standard product is one which is different, obviously because it is deficient or inferior in terms of safety, from the standard product: and where it is the harmful characteristic or characteristics present in the non-standard product, but not in the standard product, which has or have caused the material injury or damage.[71]

He then proceeded to compare the bags of blood. The outcome of his comparison was that the bags of blood which contained the harmful characteristic (the virus) were different from the other bags not containing the harmful characteristics (the virus). Those which contained the harmful characteristic (the virus) were regarded as "non-standard product" thus, those bags were defective.

The next enquiry after this classification was 'whether the public at large accepted 'the non-standard nature of the product' i.e. whether they accept that a proportion of the product was defective.[72] In ascertaining this, the legitimacy of the expectation needed to be expected must be assessed based on the following considerations: such as warnings and presentation of the product. In view of this, the issue whether it was practicable, possible, costly or difficult to prevent the harmful characteristics inherent in the product was irrelevant in determining legitimate expectation of the consumer.

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[69] S*upra* at355
[70] See Shanti Williamson, *Compensation for infected Blood Products*: *A and others v National Blood Products and Another* E.J.C.L. Vol. 7.5 Dec 2003.
[71]*Supra* at 317
[72]*Supra* 340

From the above it can be deduced that the consumer expectation test was framed in a way to exclude the consideration of the conduct of the producer at any point.

Ascertaining Defectiveness (US Perspective)

Strict liabilityas a theoretical principle of resolving product liability claim in the United states was first employed in the case of *Greenman v Yuba Power Product Inc*[73]. Section 402A of Restatement of Torts 2d contains a typical strict liability provision in America, since there are various models.[74]

In those jurisdictions where strict liability is recognized in the United States of America, to ascertain whether a defect exists or not, courts customarily use either of these two tests; (a) Consumer-expectation test and (b) Risk-utility test.

Consumer - Expectation Test

This is based on the legitimate expectation of the consumer and it is highlighted in comments (g) and (i) of the provisions of section 402A of Restatement Second of Torts. The major shortcoming of this test is how does one ascertain the legitimate expectations of customers?

b. Risk – Utility Test

In terms of origin, the risk utility test is traceable to Judge Learned Hand's decision in the case of *United States* v *Caroll Towing Co.*[75] This was a case in which the learned judge propounded the following formula as parameter to ascertain defectiveness. "If the probability [of harm] be called P; the injury L and the burden [of adequate precautions] B; liability depends upon whether B is less than L multiplied by P: i.e. whether B<PL.

The current practice in America is that either 'the risk utility test' or 'consumer expectation test' is adopted to ascertain product defect. However, due to the short comings of both tests, coupled with the warranty-tort origins of American product liability law, some jurisdictions have combined the two tests.

The provisions of section 402 A of Restatement Second of Tortswas applied in the case of *Cunningham v Mac Neal Memorial Hospital.*[76]The plaintiff's action which was founded on the strict liability principle was dismissed on the ground that it did not disclose a cause of action. On appeal, the appellate court reversed the trial court's decision and rejected the following argument canvassed by the Respondent:

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[73] 377 P 2d 897 (1963)

[74] From the provisions of Section 402 A, the following essentials must be established before any facility rendering blood transfusion could be held culpable in states which adopt strict liability in the model stipulated in this provision:

a. That the seller was engaged in the business of selling the product which caused the harm.
b. That the product was defective when it was sold.
c. That the product was unreasonably dangerous to the user or consumer.
d. That the product was intended to and did reach the consumer without substantial change in the condition in which it was sold, and
e. That the product caused physical harm to the consumer.

[75] 159 F2d 169 (2d Cir, 1947)

[76]47 III.2d 443, 266 N.E. 2d 897 (1970).

a. That blood is not a 'product' as contemplated within the provisions ofSection 402A Restatement Second of Torts.

b. That strict tort liability applies to sales while blood transfusion is a service.

c. That the hospital is not engaged in the business of selling blood consequently the hospital should not be held strictly liable in tort for contaminated blood; and

d. Medical science cannot detect the serum hepatitis virus in whole blood, therefore the hospital should not be held liable for selling blood containing such virus.

Upon resolving the above issues in favour of the appellant, the court concluded as follows on each of those grounds:

a. On the first ground that blood qualifies as product within the context of section 402A of the Restatement Second of Torts. The court further observed that comment (e) to section 402A of the above provision provides that section (e) is not limited to product that have undergone processing before sale.

b. On the second and third grounds the court rejected these arguments on the ground that Restatement Second of Torts does not require a seller to be solely engaged in the business of selling the product; since a hospital is within the distribution chain it meets the Restatement requirement of a seller.

c. On the fourth ground, the court rejected the argument that detecting serum hepatitis is impossible, blood transaction fall under the acknowledged category of being an 'unavoidable unsafe product' within comment (k) of Section 402A, Restatement 2d of Torts.[77]

The court was able to differentiate hepatitis infected blood from the 'unavoidably unsafe product' in comment (k) by observing as follows:

> We believe it clear that the exception set forth in the quoted comment relates only to products which are not impure and which, even if properly prepared, inherently involve substantial risk or injury to the user, such exception cannot avail where, as here, the product is alleged to be impure.[78]

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[77]*Unavoidably unsafe product.*'There are some products which, in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use. These are especially common in the field of drugs. An outstanding example is the vaccine for the Pasteur treatment of rabies, which not uncommonly leads to very serious and damaging consequences when it is injected. Since the disease itself invariably leads to a dreadful death, both the marketing and the use of the vaccine are fully justified, notwithstanding the unavoidable high degree of risk which they involve. Such a product, properly prepared, and accompanied by proper directors and warning, is not defective, nor is it unreasonably dangerous. The same is true of many other drugs, vaccines, and the like, many of which for this very reason cannot legally be sold except to physicians, or under the prescription of a physician. It is also true in particular of many new or experimental drugs as to which, because of lack of time and opportunity for sufficient medical experience, there can be no assurance of safety, or perhaps even of purity of ingredients, but such experience as there is justifies the marketing and use of the drug notwithstanding a medically recognizable risk. The seller of such products, again with the qualification that they are properly prepared and marketed, and proper warning is given, where the situation calls for it, is not to be held to strict liability for unfortunate consequences attending their use, merely because he has undertaken to supply the public with an apparently useful and desirable product, attended with a known but apparently reasonable risk.'

[78]47 III. 2d 443, 456, 266 N.E.2d 897, 904 (1970)

Damages

Traditionally, the purpose of damages in a tort claim is to compensate the injured party, and not to allow him profit from such loss. Damages is defined as 'money claimed by or ordered to be paid to a person as compensation for loss or injury'[79] To Frank Gahan damages is "the sum of money which a person wronged is entitled to receive from the wrongdoer as compensation for the wrong".[80]

Otton LJ while commenting on the *quantum* of damages in tort in the case of *Indata Equipment Supplies Ltd* v *ACL Ltd*[81]observed as follows: 'In my view, the correct measure of damages was undoubtedly on a tortious basis, i.e. such sum as would have put the plaintiffs into the position it would have been had it not been for the tort'.[82]

The following damages are recoverable under both the negligence and strict liability regimes in Nigeria and in those jurisdictions forming the basis of our comparative discussion in this work for injury sustained during the course of transfusion therapy:

i. Loss of wages, cost of medical expenses and other associated losses which can be ascertained and proved, all these qualifies as compensatory damages.
ii. Non-economic losses are subjective, and these include damages associated withpain, suffering and physical impairment, emotional torture and other associated inconveniences. In ascertaining the amount recoverable under this head of damage the courts consider, the past, present and future as it will affect the wellbeing of the claimant and use that as basis of its awards.
iii. Damages are also recoverable under the negligence and strict liability regimes for death and personal injury if same was due to malpractice arising from blood transfusion.[83]

Applicable Defenses under the Negligence Regime

The following defences are available in all the jurisdictions forming the basis of our discussion in this work save for the fact that the period of time reckoned to constitute the number of days when an action is said to be statute barred or falls outside the limitation period varies from jurisdictions to jurisdiction.

Contributory Negligence

Contributory Negligence is '... plaintiff's own negligence that played a part in causing the plaintiff's injury and that is significant enough (in a few jurisdictions) to bar the plaintiff from recovering damages'.[84]

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[79] Black's Law Dictionary, 7thed.
[80]Frank Gahan *The Law Damages*(1936) 1.
[81][1988] 1 BCLC 42.
[82]*Ibid*
[83] Section 45(1) of the Act defines personal injury to include any disease and any other impairment of a person's physical or mental condition. The definition of personal injury as stated above is wide enough to cover instances of food poisoning and organic injury. It must be borne in mind that personal injury occasioned by a defective product may manifest itself in varying forms; which may comprise of any of the following: un-wanted pregnancy caused by failure of contraceptive, food poisoning and psychiatric injury amongst a host of other similar instances.
[84] Black's Law Dictionary 7thed.

Where a patient under emergency informs the doctor of his blood group and the doctor without verifying this transfused the patient with the group of blood claimed to be suitable to him, such patient would be taken to have contributed to whatever damage he may have suffered; though this will not relieve the doctor from liability. The implication of this is that the damages to be awarded will be apportioned between the patient and the tortfeasor on the basis of their respective contribution to the injury.

Prescription and Limitation

The above defences are also available in all the jurisdictions discussed in this work

Prescription is described as "the effect of lapse of time in creating and destroying rights,[85] while limitation is defined as a statutory period after which a lawsuit or prosecution cannot be brought in court."[86] The limitation period in respect of tort is provided for in *section 2* of the *Limitation Act 1980*,[87] which provides as follows: 'An action founded on tort shall not be brought after the expiration of six years from the date on which the cause of action accrued.'

Defences under the Strict Liability Regime

The statutory defenses recognized under the strict liability can be briefly summarizedas follows:

(1) The defect is attributable to compliance with any requirement imposed by or under any enactment or with any community obligation.[88]
(2) That the supply was made otherwise than in the course of business and others.
(3) That the defect did not exist in the product at the relevant time when it was supplied.
(4) Development risk defence.[89]

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[85] Black's Law Dictionary, 7thed.

[86]Black's Law Dictionary *Supra.*

[87] See also Limitation Law of Ogun State of Nigeria Vol. 3, 2006, which prescribed 6 years as the period of limitation for torts in Ogun State Nigeria.

[88] See also s. 2(2) of the European Communities Act 1972.

[89] Section 4(1) provides as follows: 'In any civil proceeding by virtue of this Part against any person ('the person proceeded against') in respect of a defect in a product it shall be a defence for him to show –

(a) That the defect is attributable to compliance with any requirement imposed by or under any enactment or with any community obligation
(b) That the person proceeded against did not at any time supply the product to another
(c) That the following conditions are satisfied, that is to say-
(i) that the only supply of the product to another by the person proceeded against was otherwise than in the course of a business of that person; and
(ii) that section 2(2) above does not apply to that person or applies to him by virtue only of things done otherwise than with a view to profit;
(d) That the defect did not exist in the product at the relevant time
(e) That the state of scientific and technical knowledge at the relevant time was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his product while they were under his control
(f) That the defect-
(i) constituted a defect in a product (the subsequent product) in which the product in question had been comprised;

The above defences are also recognized under the strict liability regime in the United States of America. It must be stated that while the following defences are self-explanatory,[defects relating to compliance with any requirement imposed by or under any enactment or with any community obligation, supply made otherwise than in the course of business and that defect did not exist in the product at the relevant time when it was supplied];the developmental risk defence has been the subject of several literatures which has attracted diverse comments. In view of this and unlike the other defences which arehighlighted above; a little space will be devoted to the discussion of this defence in this segment because of its relevance to blood transfusion therapy.

The effect of this defence is that if successfully invoked the tortfeasor will escape liability for the injury emanating from defective blood product.This is possible once it is established that the state of scientific and technical knowledge at the relevant time was not such that a producer of similar products as the product in question might be expected to have discoveredsuch defect if it had existed in his products while under his control.[90] This is an issue that has generated and is still generating controversies in various jurisdictions.

(ii) was wholly attributable to the design of the subsequent product or to compliance by the producer of the product in question with instructions given by the producer of the subsequent product.

(2) In this section 'the relevant time', in relation to electricity, means the time at which it was generated, being a time before it was transmitted or distributed, and in relation to any other product, means-

(a) If the person proceeded against is a person to whom subsection (2) of section 2 above applies in relation to the product, the time when he supplied the product to another

(b) If that subsection does not apply to that person in relation to the product, the time when the product was last supplied by a person to whom that subsection does apply in relation to the product.'

[90]The inclusion or otherwise of this defence attracted a lot of controversies. While the European Commission supported liability for development risks, the Parliament supported the existence of the defence. For further reading on preliminary steps and issues involved before the defence was finally included in the Directive, see Miller and Goldberg *Product liability* 2nd Ed. (Oxford University Press), para. 13.26-13.30. This led to the provision of Article 15(b); but it must be noted that all member states including France have adopted national legislation to implement the provision of the Directives. More importantly all member states except Lusembourg and Finland have adopted the development risk defence save for Germany which removed pharmaceuticals products and Spain which also remove medicine, food or food product meant for human consumption from the scope of the defence. Also, to be noted, is the fact that France also excluded product derived from human body. See Miller and Goldberg *Supra* para. 13.40. of the Directive which allows member states to derogate from Article 7(e) which allowed development risks defence. Article 7(e) provide as follows:

'that the state of scientific and technical knowledge at the time when he put the product into circulation was not such as to enable the existence of the defect to be discovered.' While S. 4(e) of the Act which deals with the defence provides as follows:

'that the state of scientific and technical knowledge at the relevant time was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his products while they were under his control.'

The wordings of the 'Act' is different from that of the 'Directive', while the Directive focuses on state of knowledge enabling discovery of a defect; the 'Act' emphasis the conduct of the producer. A.M. Clark, *Product Liability,* Sweet and Maxwell (1989) 153. The difference in wording led to the initiation of infringement proceedings in the European Court of Justice, in the case C-300/95 *Commission v United Kingdom* [1977] ECR 1-2649. The case was initiated Under Article 169 based on the failure of the United Kingdom to implement the Directive correctly. The case was however dismissed. For

The developmental risk defence in respect of blood transfusion came up for consideration in the case of*A v National Blood Authority*.[91]

Burton J accepted the claimant's submission in this case and held as follows:

> If it is a known risk, i.e. the existence of the defect is known or should have been known in the light of non-Manchurianly accessible information,[92] then the producer continues to produce and supply at his own risk. It would, in my judgment, be inconsistent with the purpose of the directive if a producer, in the case of a known risk, continues to supply products simply because, and despite the fact that, he is unable to identify in which if any of his products that defect will occur or recur, or, more relevantly in a case such as this, where the producer is obliged to supply, continues to supply without accepting the responsibility for any injuries resulting, by insurance or otherwise...the existence of the defect is in my judgment clearly generic. Once the existence of the defect is known, then there is then the risk of that defect materializing in any particular product.[93]

The developmental risk defence is very helpful in blood transfusion therapy liability in that it exculpates practitioners from liability in cases where the existence of a particular defect is unknown.

One major area of concern is when it comes to the interpretation of the defence on how to assess the relevant state of scientific evidence. It has been observed that the defendant is not expected to establish 'a worldwide absence of knowledge of defect.'[94] The defence should be applicable when the defendant shows that there is no previous knowledge of the defect in the 'field with which he is expected to be familiar.'[95] The relevant time to apply the test is provided in section 4(2) of the Act,[96] while under the Directive it is when the producer put the product into circulation.[97]

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further readings see Miller and Goldberg *Supra* para. 13.44-13.58. It should also be noted the words 'a producer of products of the same description as the product in question' has been subjected to criticism on the ground that it clouds the definition with inherent complications and also limit the scope of the defence. See Miller and Goldberg *Supra* paras. 13.32 – 13.35 for other criticisms.

[91] For the facts of this case, see n 68.

[92] For the so-called Manchurian example, see Miller and Goldberg *Supra* paras 13.54 and 13.87.

[93] It has been suggested that this gives little, if any, weight to Recital 7 of the Directive, which provides that: "Whereas a fair apportionment of risk between the injured person and the producer implies that the producer should be able to free himself from liability if he furnishes proof as to the existence of certain exonerating circumstances... Burton J merely referred to the purpose of Art (7) as being plainly not to discourage innovation', and as protecting 'the producer in respect of the unknown (inconnu) See J Stapleton, *Bugs in Anglo-American Product Liability* 53 CL Rev 1225, 1249 (2002).

[94]Miller and Goldberg *Supra* para. 13.31

[95]*Ibid.*

[96] In this section 'the relevant time', in relation to electricity, means the time at which it was generated, being a time before it was transmitted or distributed, and in relation to any other product, means-

(c) If the person proceeded against is a person to whom subsection (2) of section 2 above applies in relation to the product, the time when he supplied the product to another

(d) If that subsection does not apply to that person in relation to the product, the time when the product was last supplied by a person to whom that subsection does apply in relation to the product.

[97] See section (7e) of the Directive

The issue of relevant time is bound to create problem and it is of importance in an area where the state of the art is rapidly increasing.[98]

Recommendation and Conclusion

Recommendation

While blood transfusion therapy plays a major role in saving life and promoting the health of patients, it should not be an avenue of death. Concerted efforts need be taken to ensure that practice and, service delivery, in this area of medicinal practice are properly co-ordinated, regulated with adequate legal machineries put in place to protect recipient, donors, and service providers' interest. The following suggestions are proposed towards improving and regulating the practice of transfusion therapy in this area:

(a) Establishment of appropriate administrative and legal framework that will coordinate activities in this sector. In this wise there is need to put in place appropriate guiding legislation, to regulate activities in this sector, while practice guidelineshould be outlined. These guidelines are to be constantly reviewed in line with developments in this area of medicinal practice.

(b) Guidelines should be established which will specify the procedure for the collection, storage, and transfusion process; while proper record keeping of activities should be made compulsory. Failure to follow outlined procedure should be classified as breach of duty for which the operator of such facility would be held culpable.

(c) In order to reduce the problem encountered in establishing fault on the part of injured claimants, there is need to complement the existing fault theory which is the only theoretical principle of liability with strict liability. This will promote sanity and reduce the free market practice currently operating in Nigeria.

(d) Operators and personnel to be engaged in this sector must be properly trained and retrained to ensure that guidelines are followed. It is further suggested that guidelines in line with the provisions of Royal Nursing College in Britain be introduced to Nigeria. The said document contained clear and detailed step by step procedure to be adopted towards ensuring that the likelihood of transmissible diseases is reduced to the barest minimum.

(e) The developmental risk defence should also be introduced into Nigerian jurisprudence. It is of great value to product development while it equally makes service providers not to be culpable for cases involving unknown defects.

(f) Adequate haemovigillance procedure must be put in place. This is a set of surveillance procedures covering the whole of transfusion process from collection of blood and its components to the follow up of the recipients.

[98]Miller and Goldberg *Supra* para. 13.43

(g) Continuing legal education for practitioners in this field should be made mandatory and also made a condition precedent for the renewal of their practicing license.

Conclusion

The process of safe transfusion is a complex one which involves several hospital staff and departments, it also entails multiple steps. There is need to consider risk reduction strategies which will assist in reducing to the barest minimum transfusion errors.Such a reduction will ensure that incidents of transmissible diseases are reduced to the barest minimum. Towards achieving this, adequate quality control systems that will reveal sharp practices, ensure correct patient identification and haemovigilance mechanisms be put in place. This becomes imperative in view of the provisions of the Constitution of the Federal Republic of Nigeria as amended which guarantees right to life. Right to safe medical is a *sine quanon* to full enjoyment of right to life.