THE SETTLEMENT OF MEDICAL MALPRACTICE DISPUTES UNDER CAMEROONIAN LAW

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ABSTRACT

In spite the fact that, Cameroon has one of the best laws regulating the practice of medicine, it is a well noted fact that, the number of medical disputes between patients and medical practitioners, health facilities as well as sanctions levied against healthcare workers by the supervisory body- The Ministry of Public Health for medical malpractice has been on the rise lately. This paper attempts to catalogue the various causes of medical malpractices disputes under Cameroonian health law. The article examines the legal implication of the breach of the patient's rights to healthcare. It investigates the legal mechanisms instituted by the law, in the resolution of any medical malpractice disputes. The paper does so through a reading of records mainly from documentary and internet search. The data thus collected constitutes the sources from which the law is drawn, stated and analysed in the light of the stated aim of the paper. The results *inter alia* show that the patient's rights to healthcare has been infringed by doctors in Cameroon. The accomplishment of such a study might be helpful not only to disseminate knowledge to medical practitioners and health facilities, but also to contribute to uphold the patient's rights to healthcare. The article then concludes by exposing the lacunae in the current law in relation to the settlement of medical malpractice disputes as well as provides some suggestions on where the law should go.

Keywords: Disputes, Medical Malpractice, Settlement mechanisms

INTRODUCTION

Medical malpractice is a source of disputes to millions of patients over the world. It deals with petition against either the medical practitioner or the health facility for the provision of a sub-standard treatment to the patient. It is a trite rule in law that every person who visits a hospital expects that his condition will be well catered for.[i] Thus, the hospital should be a centre in which patient are treated of all manner of health situation and the medical practitioner are expected to use all of their skills and expertise in the treatment of a patient and to see into it that, a person who visits a health facility should not be affected during his stay or should not affect others.[ii] Healthcare is essential to life, thus, protecting quality and controlling its provision is a key concern. The varied use of health services at clinic, hospitals, for delivery, treatment, surgery and in industry make it vital to the welfare of human kind. But, throughout history, man has been ravaged by a number of violations of their rights to health as a result of poor quality and substandard healthcare.[iii] The most pervasive medical malpractices disputes on the planet ranges from failure of the medical practitioner from treating a patient when call upon to do so, to surgical error, wrong medical prescription, misdiagnosis, nosocomial infections, to treatment without competency. The consequences of medical malpractice are devastating on the world population[iv] as it leads to birth defect, chronic pain, disability, disfigurement, increase medical expenses, loss of consortium and the loss of wages and employments. There is no doubt that this will lead to a dispute between patients on the one hand and medical practitioner or health facilities on the other hand. Hence the need for the resolution of medical disputes.

It is for this reason that most governments in the world have device legal mechanisms to settle medical disputes. It was in an effort to settle medical disputes that the Cameroon government decided to put in place several pieces of national legislation. For instance, the 1990 law[v] provides for the creation of a Medical Board to adjudicate disputes on professional misconducts, the law on Criminal Procedure Code[vi] advocates for a compromise agreement as well a judicial method of settling medical malpractice disputes by the courts of law.

It is worthwhile to define medical malpractice before getting into the crux of this paper.

THE MEANING OF MEDICAL MALPRACTICES

Medical malpractice has not been easy to define because it is taken to mean a different thing to different people. In spite of this, a few attempts have been made to define it with the etymological, statutory definitions guiding scholars of law and the courts both of which shall be examined in the paragraphs that follow.

The etymological meaning of medical malpractice

The term malpractice comes from the Latin phrase "*mala praxis*" that was coined by a British legal Scholar Sir William Blackstone in his "Commentaries on the Laws of England". He described neglect or unskilled management by a physician as "*mala praxis*" and categorised a "*mala praxis*" claim as a private wrong and not as a contract.[vii] This suggest that, medical negligence is also called "*medical malpractice*" or "*medical Praxis*"[viii] but this is not quite accurate since it includes all other forms of medical practices and makes no difference between professional negligence and professional misconduct.[ix]

The meaning of medical malpractices by legal writers

Cox, H.[x] attempts to define medical negligence as "the breach of the duty owed by the doctor to his patient to exercise reasonable care and skill, which results in some physical, mental or financial disability". This same line of thought was adopted by Bryan A Garner who defines medical negligence or medical malpractice as "the failure of one rendering professional services to exercise the degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession, with the result of injury, loss or damage to the recipient of those services or to those entitled to rely upon them."[xi]

In the view of Cox and Bryan**,** medical negligence is a form of negligence in which a patient brings an action for damages in a civil court against his medical practitioner, who owed him a duty of care in tort, if he had suffered injury in consequence of negligence or unskilled treatment.[xii]

Accordingly, so far as persons engaged in the medical professions are concerned, every person who enters into the profession undertakes that, he is possessed of a reasonable degree of care

and skill to give medical advice and treatment. Such a person, when he is consulted by a patient owes him or her certain duties such as: the duty to decide whether to undertake the case, the duty of care to decide the whole treatment to give and a duty of care in the administration of the treatment. The breach of any of those duties is what is known as "medical negligence" for which the patient gets a right of action for damages or on the basis of which; the patient may recover damages from his doctor.[xiii] The definition is based upon the existence of guilt and such negligence and duty are correlated to each other. The question of medical negligence could not be viewed in isolation of the duty of care.

This view is shared by Louise S.[xiv] who is of the opinion that, the term medical malpractices also known as "bad practice" or "professional negligence' can be defined as "the failure of a professional to use the degree of skill and learning commonly expected in that individual's profession, resulting in injury, loss or damage to the person receiving care." For example, a physician not administering a tetanus injection when a patient had puncture wound or a nurse performing surgery without having any training. [xv] In the same line of thought, the same author is of the view that, medical negligence can be described as "the failure to give care that is normally expected of a person in a particular position, resulting in injury to another person"[xvi] An example includes an infection caused by the use of non-sterile instruments.

These definitions emphasize the purpose of medicine which has always been to cure disease and eventually to prevent it. Medicine always meant service, therefore at all times certain qualities are required of the physician such as readiness to help, knowledge concerning the nature of disease and skill in curing the sick man.[xvii] Doctors are expected to fill in for their patients in the very same way the lawyers fill for their clients. This role is necessary because, sick people are no more capable of navigating complex health care system, than are accused persons capable of navigating the complex legal system.

The meaning of medical malpractices according to case law

In terms of torts, negligence is said to be "the breach of a duty caused by omission to do something which a reasonable man would not do or doing something a prudent and reasonable man would not do".[xviii] The definition makes no difference between medical negligence and non-medical negligence. As the term itself suggest, medical negligence relates to the medical

profession and it is the result of some irregular conduct on the part of any member of the medical profession or better still it relates to services on the part of any member of the profession or related service in the discharge of his professional duties.

If this meaning is accepted as precise definition of the concept of medical negligence, then difficulty would be posed to distinguish between professional and medical negligence and also to distinguish between improper and irregular conducts. The former relates to the duties of the doctor towards his patient wherein if there is consequential damage to patient charges are brought before the court of law. The latter relates to the violation of code and ethics and medical practice wherein damage need not be there yet charges are brought before the disciplinary board of the medical association for instance criminal abortion, adultery and advertisements.

In terms of the concept of "duty of care", professional negligence in case of doctors has been described as "lack of reasonable care and skill whereby the health or life of a patient is endangered."[xix] This definition cast a moral obligation on the medical man to assist a patient with his expertise. Every doctor will be bound to treat ill persons who visit him or her with the request of medical assistance. The questions arise as to the exact points in time when the duty of the medical man initiates and when the doctor owes a duty of care to a particular ill person.

It can be said that, the obligation of the medical man starts from the points in time when he accepts rather than initiates the treatment of a patient. From then on, he is bound to exercise due care and caution, utilizing his or her professional knowledge and skill for the welfare of the patient. Still the question remains on what constitute reasonable care and skill? What are the standards to be adopted in determining lack of reasonableness? Thus, the definition has failed to lay down parameters for interpreting the term "reasonable" and "reasonable skill". All this crack confusion not only for the patient but also for the medical man.

A more appropriate and acceptable definition can be found in a famous *Bolam's* case[xx] Wherein McNair J was of the opinion that, to a medical man, medical negligence means "failure to act in accordance with medical standards in vogue which are being practiced by an ordinary and reasonable competent man practicing proper standard, if the medical man conforms with any one of those standards, then he is not negligent".[xxi]

Justice McNair seems to have focused on the test to determine the liability of the medical man rather than analyzing the appropriate definition of the concept of medical negligence. Each word used in the analysis is so vulnerable in different interpretation. For example, words like reasonable and competent doctor, medical standard and so on. This definition ensures protection to the medical man instead of covering the components of the term of medical negligence. As such, it does not highlight the issue of basic ingredient except stating the failure to act according to the medical standard.

However, this view of McNair cannot be rejected out rightly as it is necessary to understand what may or may not amount to medical negligence. Several questions came up for the consideration of the court such as; would a competent medical practitioner operate in those circumstances? On the perusal of the evidence of the medical experts, the courts found that, there was erroneous surgery. The court in its conclusion held that, it is a case of medical negligence by which the patient died.

These views seem to have been summed up by the American case of *Hall v Hilbun*[xxii] in which C.J. Robertson was of the opinion that, "medical malpractice is a legal fault by a physician or surgeon. It arises from the failure of a physician or surgeon. It arises from the failure of a physician to provide the quality of care required by law. When a physician undertakes to treat a patient he takes on an obligation enforceable at law to use minimally complete care in the course of services he provides. A physician does not guarantee recovery. A competent physician is not liable *per se* for a mere error of judgement; mistaken diagnosis or the occurrence of an undesirable result."

The statutory meaning of medical malpractice

The World Medical Association in article 2(a) provide as follows: "Medical malpractice involves physician's failure to conform to the standard of care for treatment of the patient's condition or a lack of skill or negligence in providing care to the patient which is the direct cause of an injury to the patient"[xxiii]. This points out to the grounds for the existence of liability for medical negligence or better still, the elements for the existence of medical liability. It suggests that, for a medical practitioner to be held liable for medical negligence the claimant must prove that the physician failed to conform with the standard that is expected from a

reasonable professional in that art. The claimant must equally prove that, the standard of care was not complied with by the medical practitioner through his or her lack of skill in the provision of the health care to the patient and finally that that breach of obligation by the medical practitioner is the direct cause of the injury to the patient.

To canvassed the strictness of the above provision of the law, section 2(b) of the Association provides that "an injury occurring in the course of medical treatment which could not be foreseen and was not the result of any lack of skill or knowledge on the part of the treating physician is an untoward result, for which the physician should not bear any liability." Put in other words, an act shall not be considered as a medical malpractice if it can be proven by the health professional that it did not result from his lack of skill or better still that, irrespective of his or her compliance with the required degree of care expected from a professional in that circumstances, the injury however resulted. In such cases, the law is of the opinion that he shall not be held liable for medical negligence. Thus, liability for the purpose of medical negligence shall be taken to mean "the breach of a legal duty to take care which results in damage undesired by the defendant to the plaintiff".[xxiv]

Be all these as they may, the bottom line is that, medical malpractice resolves around a substandard treatment provided by a heath facility or a medical practical that rather than curing the patient, instead constitutes the reason for which, his health condition deteriorates.

After explaining what medical malpractice is, the paper will now focus on the different categories of medical malpractices that give rise to a dispute between patients and the medical practitioner or health facilities in the provision of health care in Cameroon.

CAUSES OF MEDICAL MALPRACTICE DISPUTES

The central issue of this paper is to find out the causes of medical malpractice disputes. This section of the article attempts to "X-ray" the different forms of disputes existing between medical practitioners and patients.

Failure to attend or treat

One of principal cause of disputes between a doctor and a patient is the former's failure to attend to the call of the latter. Various factors are to be taken into consideration to determine whether the failure constitutes a malpractice or not. This will include the practitioner's commitment with other patients at the same time. In *Barnes v Crabtree*[xxv] the plaintiff brought an action against the defendant for failing to treat her alleging that, the defendant on examining her stated that there was no illness and if she was not satisfied, she could also consult another physician. The court held that, the doctor's obligation was to render all proper and necessary treatment to the patient. In the Cameroonian *locus classicus* of *Ministere Public et Nkoumou Tsala Gilbert c/ Yong Bang Arnold et Eben Emmanuel Martin et autres*[xxvi] the Court of appeal found Dr Bang not guilty and so was discharged and acquitted, while Dr. Eben was convicted for failing to attend to a patient. The same is true in *The People v Ginazen Eric*[xxvii] in which the defendant was held liable for failure to attend.

Failure to take a full medical history

Error in diagnosis and treatment occurs for various reasons such as, the failure in taking medical history, in examining the patient, in analyzing the patient's symptoms, failure to conduct proper pathological test and this constitutes a second cause of a medical malpractice disputes. Before embarking upon the treatment, it is necessary to take full and complete medical history of the patient and the failure to do so will result in serious consequences. The classical example was *Hollinsworth Dartford v Gravesham Health Authority*[xxviii] where prior to conducting a caesarean operation under general anaesthetic, the anaesthetist did not take the required pre-emptive history which would have revealed a history of allergy and asthma. The petitioner became ill due to allergic reactions to the drugs yet the anaesthetist administered further doses. Without this prior knowledge of the patient's medical history of allergic reaction the petitioner developed a serious illness. It should be noted that, had the complete history been taken, further deterioration of illness would have been avoided. Taking medical history of the patient does not confine to only seeing the signs and symptoms of the illness for which the patient suffers the medical therapy, it also involves making inquiry about the previous treatment taken for the same conditions and this has been the grievances of most patients.

Failure in diagnosis

The issue of whether the error of clinical judgement constitutes a source of dispute between medical doctors and patients is a very difficult task. In France, the *Bianchi* decision,[xxix] of the *Conseil d'Etat* set out several necessary acts for the treatment or diagnosis of the patient with an exceptional but known risk, absence of any predisposition of the patient of such risk, damage directly related to the achievement of hazard and extremely serious injury. Compensation was to be granted only for the disorder that presented an obvious abnormality that was out of proportion to those that a patient suffered before the care and did not contribute a reasonably foreseeable judgment of the patient's previous state. Similarly, in *Draon v France*,[xxx] the decision of the European Court of Human Rights compelling the defendant to the payment of compensation was based on a dispute that arose between the medical practitioner and the patient when the latter alleged that, it was the wrong diagnoses of the healthcare provider that led to the delivery of a disabled child.

In England, the House of Lords in *Whitehouse v Jordan*[xxxi] observed that, "merely describing something as an error of judgement does not indicate anything about whether it is negligent or not." The true position in error of judgement may or may not be negligent. "It does depend on the nature of the error. If it is one that would not have been made by a reasonable competent professional man professing to have that standard and type of skill that the defendant held himself out as having and acting without ordinary care, then it is negligence. If on the other hand, it is an error that a man, acting with ordinary care might have made, then this error of judgement is not negligence."[xxxii] A similar reasoning is advanced in France in which the courts in general are not very demanding for negligence to be established so that the victim can be compensated as misdiagnosis is not considered a fault *per se*.[xxxiii] The physician is considered negligent only if he or she failed to gather the necessary resources to complete his or her mission.[xxxiv] Hence the persistence of the doctor to his or her diagnosis in spite of sign justifying a review of such diagnosis is a malpractice.[xxxv]

The failure to diagnose will be a malpractice if the doctor does not show reasonable competency or falls below the standard of a reasonable competent skillful medical professional man. In *Wood v Thurson*,[xxxvi] a drunken man was brought to the emergency unit of the hospital with a history of having been run over by a motor lorry with 18 broken ribs, a fractured collar

bone and badly congested lungs. The surgeon neither did examine as closely as required nor uses his stethoscope to discover the patient's true condition. Added to that, he permitted the patient to return home where after a few hours he died. The surgeon was found negligent in failing to make proper diagnosis. In *Payne v St. Hillier Group Hospital Management Committee,*[xxxvii] the patient was kicked in the abdomen by a horse. The surgeon saw a bruise but concluded that, there was no internal injury. The patient was allowed to go home and subsequently he developed a fatal degree of peritonitis. It was held that, the doctor should have re-checked his own diagnosis after further observation and should have obtained a second opinion. The failure to re-diagnosed properly following changes and development in the patient's sign and symptoms was malpractice.

Similarly, in *Hotson v East Berkshire Area Health Authority,*[xxxviii] a child's hip was injured in a fall. At the hospital the injury was not correctly diagnosed and the child was sent home. Subsequently, when he was in pains he returned to the hospital. When the nature of his injury became apparent, he was given emergency treatment. His condition was such that he was found with a severe condition causing deformities in the hip joint. He claimed for negligence basing his claim for delay in diagnosis. This, the hospital admitted was a breach of duty. But the hospital argued that, the resulting delay had not adversely affected the plaintiff's long-term condition. At the trial the judge held that even if the doctors at the hospital had correctly diagnosed the plaintiff's condition when he came at the first time, there was still a 75% risk of the disability developing. The breach of duty has turned that risk into inevitability, thereby denying the plaintiff 25% of the full value of the damages awardable for the plaintiff disability. The decision was affirmed by the court of appeal. The House of Lords reversed this. They held that, since the judged had held on a balance of probabilities given the plaintiff's condition when he first attended the hospital, that even correct diagnose and treatment would not have prevented the disability from occurring. The plaintiff had failed on the issue of causation.

Similarly, the defendant was held liable under this head in *Headfield v Crane*[xxxix] where the claimant developed a lung cancer to the breast but no biopsy was undertaken to confirm a diagnosis of fibro adenoma, as opposed to carcinoma as in fact was the case where chemotherapy was thereby unduly delayed. In Cameroon, the rule that the failure of diagnosis would be a medical malpractice if it is one that would not have been made by a reasonable

competent professional man professing to have that standard and type of skill was followed in the Littoral Court of Appeal Case of *The People and 2 Others v Ndeumeni Noubevam Charles Dechateau and Ministry of Public Health,*[xl] in which the court held the defendant liable for failing to diagnose the patient's condition thus leading to a substandard treatment. Another case in point in which a wrongful diagnosis shall lead to the liability of the medical practitioner is the decision of the Mbouda Court of First Instance in which the court held that, the failure of the medical practitioner do produce same is a malpractice.[xli]

Failure to consult or refer patient to a specialist

A further cause of dispute between a professional man and a patient deal with situations where a medical practitioner comes to know that, the diagnosis or treatment is beyond his or her capacity or involves complications, but fails to summon another practitioner who has the necessary ability or refer the patient to a specialist. The duty to refer patient to a specialist is strictly regulated by the law. For example, the World Medical Association's (WHA) International Code of Medical Ethics provides that, "Whenever an examination or treatment is beyond the physician's capacity, he should consult with or refer to another physician who has the necessary ability."[xlii] If he or she fails to do so by diagnosis himself or herself undertaking the act beyond his or her competency he or she will be guilty of medical negligence if the harm occurs. Thus, if a doctor suspect cancer, he must immediately refer the patient to a specialist or arrange for an immediate biopsy as a failure to do so will constitute a medical malpractice.[xliii] Similarly, a consultant who comes across a difficult problem in treatment has the obligations to refer same to a specialist or seek advice from the specialist concerned[xliv] and where a doctor, who fails to interpret a cytology report correctly, owes an obligation to seek clarification of the report and advice for further investigation.[xlv] In *Poole v Morgan*[xlvi] wherein the ophthalmologist who did not have the necessary training as to the use of laser, performed retina ulcerous which was normally done by specialist. It was found that since he did not possess the expert skills it was his duty to refer the patient to the specialist.

Also, in *Robinson v Jackson*[xlvii] a consultant pediatrician was held liable for failure to refer a hydrocephalic baby suffering symptom consistent with blockage of it ventricular peritoneal shunt. On referral, it was the duty of the medical practitioner to whose care the patient was referred to make proper inquiries to discover what treatment, if any, a patient has already

received elsewhere failure to which his liability shall be established on the grounds of wants of proper inquiries of previous treatments.[xlviii] On the strength of the provision of Article 1340-1 of the Civil Code (CC) "a person who has caused harm to another while lacking understanding is nonetheless obliged to make reparation for it." This suggests that, competent professionals are expected to realize which tasks lies beyond their competence and to refer the patient to appropriate specialists. Finally, in the Cameroonian case of *The People and 2 Others v Ndeumeni Noubevam Charles Dechateau and Ministry of Public Health*, (supra) a dental surgeon who did not have the necessary training performed a surgery on the claimant which was normally done by a general doctor it was found that, his failure to refer the patient to an expert possessed with skill will be negligence as the treatment falls below the standard expected of a reasonable competent professional man.

Treatment error

It has been generally acknowledged that, treatment error is a cause of dispute between a healthcare provider and the patient. The error of treatment arises on account of various reasons such as the professional's lack of adequate skills and knowledge in exercising a particular method[xlix] or departure from the standard procedure approved by the medical body.[l] However, all cases of error or mistaken treatment do not constitute negligence. As the Bolam test indicate only the error which would not have been committed by a reasonable competent practitioner exercising ordinary care amounts to negligence. The aggrieved party must prove that, it was unreasonably an error. Therefore, to describe an error as an "error of professional judgement" in deciding issues of malpractice, it must be shown that, the medical practitioner has fallen below the proper standard. On the other hand, if the practitioner proves that, he or she was acting within or in accordance with the mode of practice accepted as proper by a reasonable body of practitioners and that, he was using the requisite degree of skill and care during the administration of the treatment, he will not be negligent of the mistake that occurred. Thus, in *Whitehouse v Jordan*,[li] the doctor was alleged to have pulled out the child in the course of a forceps delivery and alleged negligence in failing to do caesarean section delivery. The court rejected the accusation by holding that, the defendant was not guilty of negligence. In the court's opinion the treatment does not constitute negligence.

Similarly, in the Cameroonian case of *The People and Mambo Sonita Fon v Funebe Chritopher*[lii] the accused was charged for causing harm to prosecution witness by furnishing medical and surgical treatment to her in violation of Section 228(2) (c) of the Penal Code (PC). The court rejected the accusation by holding Dr. Christopher not guilty. He was accordingly discharged and acquitted and in respect of the civil claim of 80 million francs, the court declared itself incompetent to adjudicate on it. The learned magistrates rested her decision on the grounds that: "The accused is a qualified medical doctor, a general practitioner. The diagnosis and the treatment he offered the prosecution witness was within his reach." On the grounds of liability, she continued that: "the accused can only be found guilty if it is proven beyond reasonable doubt that he caused the injury intentionally as per Section 74 of the PC, criminal responsibility shall only lie on a person who intentionally commits each of the ingredients."[liii] In contrast, the medical practitioner would be found guilty for attempting to deliver a child by forceps when it was too far in the mother's pelvis and for failing to undertake a caesarean delivery.[liv] In *Bowers v Harrow Health Authority,*[lv] a doctor was held to have been negligent in pulling too hard during a delivery process thereby causing traumatic injuries to a child's brain.

Surgical errors

A non-negligible cause of dispute between a medical practitioner and a patient is in the domain of surgical errors. This refers to medical malpractices litigations where the plaintiff alleges that an injection is administered in the wrong place or contain the wrong substance or needle breaks in the medical treatment. A case in point is that of *Agborock Lydienne v Dr. Nwaobi Romanus and St. John of God Hospital Nguti.*[lvi] The fact of this case briefly stated, a surgeon performed an operation on the patient leaving a swab in him. The court observed that, had the defendant exercised the care and skill reasonably expected of a surgeon he would not have injured the patient. Thus, the treatment was constitutive of a malpractice. Another example of this kind of medical malpractice is where gauze was left in the patient's body after an operation[lvii] or in *Gerber v Pines*[lviii] where in giving treatment by injection, a needle was broken and left in the patient's body and the patient was not informed. Furthermore, in the case of *Mahon v Osborne*[lix] a surgeon was held liable in negligence when he left a swab inside the body of his patient after a surgical operation. On the other hand, negligence was not found where an anesthetist had adopted a technique during a caesarean section generally accepted by a body of

medical opinion alleging it did carry with it some risk of slight awareness during the surgical procedure.[lx] Equally, in *Venner v North East Essex Health Authority*[lxi] negligence was not found where a gynecologist performed a sterilization operation upon a patient who informed him in error that she was not pregnant.

In the French legal system, the French courts have equally held medical practitioners and hospitals liable for medical malpractice for the failure to perform a medical procedure. In a French court's decisions namely, the *Guyot's* case,[lxii] Mrs Guyot underwent, on the 20th of January 1984, a hysterectomy at the Châtillon-sur-Seine hospital center. During this procedure, the patient suffered a tear in her bladder wall causing a vesico-vaginal fistula. She sued the hospital in the Nancy Administrative Court that issued a decision on the 18th of October 1988, holding the hospital liable. On appeal before the Nancy Administrative Court of Appeal, the decision of the lower court was reversed on the grounds that the carelessness attributed to the surgeon cannot be regarded as constituting a serious fault capable of committing the liability of the hospital. Dissatisfied by this decision, the plaintiff filed an appeal before the *Conseil d'Etat* who reversed the decision of the Appeal Court and held the hospital liable. Ruling in 1997, the *Conseil d'Etat* could naturally not accept this reasoning since it had itself decided, in 1992 as the court held that, "the fact that the surgeon did not observe the tearing of the bladder wall constitutes a lack of attention on his part."[lxiii]

Other traces of the court's position in which fault was retained after 1992 include the case of *Époux Vergos.*[lxiv] In this case the relief granted was founded on the existence of a gross negligence or gross misconduct on the part of the medical practitioner or the hospital. In the case of *Centre Hospitalier (CH) de Pontoise/Mlle Matin*[lxv] the liability was based on the excessive doses of radiation; while in the case of *Dame Juyoux*[lxvi] the liability was based on the negligent administration of anaesthesia, as the medical practitioner in this case did not take into account the anatomical peculiarity of the patient. In a further French decision during this period, the court in the case of *Mme Pecke*, [lxvii] placed the liability of the practitioner on the grounds of an accidental damage to an organ and a lack of knowledge of the rules governing surgical techniques. The reason for this liability was also suggested in the case of *Mme P.*,[lxviii] in which the court sanctioned the accused for the perforation of the defendant's uterus, in as much as the court has in one case held that the wounding of the arm of the fetus following an

amniotic puncture that wounded the fetus at two places on the left cheek during an amniocentesis[lxix] was a breach of the surgeon's duty of care thus leading to the liability of the medical practitioner. Finally, in obstetric matters, the misapplication of forceps, while the practitioner did not have a precise knowledge of the position of the child, had been considered an act of negligence.[lxx]

Similarly, the forgetting of various objects, such as compresses, of a foreign body visible on an X-ray in the lip of a patient,[lxxi] or of a metallic piece found during another procedure[lxxii] or of the surgical fields,[lxxiii] in the patient's body or the error on the part of the body to be treated are the most common forms of surgical malpractice disputes. A good example include the case of *M.A/CH du Havre*[lxxiv] in which the *Conseil d'Etat* held the Havre hospital liable to pay damages for injury sustained by Mr A following a second intervention to remove a forgotten compress in a patient's body.[lxxv] However, this should not be construed to mean that any injury committed by the medical practitioner on the body of the patient would give rise to an action for the payment of damages as in the case of *CHR de Montpellier*[lxxvi] the action failed on grounds that, the injury alleged to have been suffered by the patient was as a result of the fragile nature of his body thus rendering the accident inevitable. In other French cases, the relief was founded upon a post-operative medical failure. One of the first cases in which the French courts stressed on this ill occurred in the case of *Mme Durand/CHR d'Angers*.[lxxvii] In the case of *Consorts Savouré/CHR Léon Binet de Provins,*[lxxviii] the Paris Administrative Court of Appeal committed the responsibility of the regional hospital Léon Binet because of anticoagulant treatment too quickly interrupted.

Finally, in a case of *M. et Mme X*.,[lxxix] the Versailles Administrative Court of Appeal convicted the Mantes-la-Jolie hospital center on grounds of the negligent of an anesthesiologist who did not undertake the clinical checks he was required to perform. In this case, Mr. and Mrs. X. sought, on behalf of their minor son Malcom and in their own name, sue the Mantes-la-Jolie Hospital Center for the payment of damages for the damages suffered by their son as a result of a careless and negligent surgery conducted by the surgeon working for the hospital on the 20th of March 2002 on their child, then thirteen months old. The decision of the court was rested on the expert evidence adduced by a medical report of an expert appointed by order of the President of the Administrative Tribunal de Versailles on the 23rd of June 2003 that revealed

that, the Young Malcom X. was wounded by the general anesthesia practiced for the surgery of the 20th of March 2002, that led to a cardiac arrest responsible for the major and irreversible neurological procedure of which he was affected.

Failure to prevent infection(s)

Another cause of dispute between the health facility and patients is the failure of the health career to protect the patient from infection during his stay in the hospital. This is medically known as a "nosocomial infection." Nosocomial infection differs from iatrogenic infection, given that the latter is caused by medical treatments or medications whereas, a Council of Europe Recommendation defines a nosocomial infections as "any hospital-acquired disease, caused by clinically or biologically recognizable microorganisms, which affects either the patient as a result of his or her admission to the hospital or care received therein, either as an inpatient or outpatient, or hospital staff, by reason of his or her activity, whether or not the symptoms appear while the patient is in the hospital."[lxxx] There are two categories of the transmission of nosocomial infections namely endogenous and exogenous transmission.[lxxxi] Most nosocomial infections have their origin either in the non-respect of the rules of hygiene by the personnel, or the wrongful organization of the hospital service. Thus, in cases where the infection was not caused by any fault of the hospital authority as to their compliance with the rule of hygiene in the establishment, no action on this ground shall be sustained. A case in point is the French court's decision of *Mme Neveu/Centre hospitalier intercommunal de Créteil,*[lxxxii] in which the French *Conseil d'Etat* held that, "the investigation that the germs which are the cause of the infection which has arisen as a result of tubal sterilization suffered by Ms. Neveu and required removal of her right ovary were already present in the patient's body before the first surgery; that in these circumstances the complainant is not justified in maintaining that the infection she suffered would in itself reveal a fault of the organization and functioning of the service."[lxxxiii]

The decision of this case greatly differs from that of *Clinique Sainte Thérèse*[lxxxiv] in which the the Court of Appeal of Rennes held the clinic liable when the patient contacted spondylodiscitis following an injection of the product by a radiologist when undergoing a radiological test in order to determine the appropriate treatment to apply for a back pain. In this case the judges pointed out that the physician and the healthcare institutions were under a duty to ensure that

patient were prevented from nosocomial infection, which they can only be rebutted by evidence that, the illness originated from an external cause independent of their making. The French law as well as the Cameroonian law is founded on the philosophical grounding that, patients should be prevented during their stay in the hospital from contacting another disease due to the hospital's failure to comply with the required rules of hygiene and safety. It should be stated that, in France, the provision of Article L. 1142-1 of the Code of Public Health, resulting from Article 98 of the Law of 4th March 2002 on the rights of the sick and the quality of the healthcare system, laid the foundations for a harmonized legal liability regime in the case of nosocomial infections, by stating that, "except where their liability is incurred as a result of a defect in a health product, health professionals as well as any institution, or organization in which individual acts of prevention, diagnosis or care are carried out shall be liable for any damage resulting from nosocomial infections, saves where the hospital can bring proof of the fact that, the infection was caused by some other factor."

Similarly, the French *Cour de Cassation* has ruled that physicians and private health institutions were under a "safety obligations of results."[lxxxv] In order words, anytime the infection may be attributable to medical care, clinics and physicians are strictly liable unless they established that, the victim's harm resulted from an external cause. In this regard, in an administrative court decision in the case of *CHU de Nimes*[lxxxvi] the Marseilles Administrative Court of Appeal refused to rely on "the external cause justifications" though in a recent case of *CHU de Bordeaux*[lxxxvii] the Administrative Court of Appeal of Bordeaux went *obiter* by relying on the "external cause justification."

Finally, it should be stated that, the English courts have upheld the principle of the liability of the hospital and the medical practitioner for hospital acquired infections. A patient should not be discharged from the hospital in an infectious condition or infect someone with whom he comes into contact. However, in such a case, the hospital owes a duty of care directly to a patient irrespective of vicarious liability.[lxxxviii] In *Headfield v Crane,*[lxxxix] after the birth of a child, the petitioner was shifted from the maternity ward to a general ward where the patient was suffering from puerperal fever, the petitioner caught an infection from this patient. It was held that, the hospital was negligent in shifting the patient to the ward where there was gravely

suspicious case of infection and in failing to warn the patient and isolate the infectious patient from other.

Wrong medication

Lastly, administering the wrong medication to a patient is one of the leading causes of medical malpractice disputes. Wrong medication can be the results of many mistakes. The wrong medication altogether may be administered by an improper dosage of the correct medicine prescribed. The following decisions illustrate instances in which disputes arose on this ground. In *Collins v Hertfordshire County Council*[xc] cocaine was injected instead of procaine and in *Jones v Manchester Corporation*[xci] Pentothal was injected while the patient was already under an anesthetic causing death to the plaintiff. Other mistakes made by practitioners include pathology, laboratory mistakes where various laboratories test used for diagnoses and sometimes treatment planning can have several types of errors. This view can be nicely illustrated in the case of *Prendergast v Sam and Dee Ltd and Others*[xcii] in which a doctor was held 25% liable for injury occurring following the incorrect interpretation of illegal handwriting on the prescription. The pharmacist was held 75% liable for misreading it, as he should have been on inquiry that the drugs thus prescribed were an unlikely combination. Similarly, in *Dwyer v Roderick and Others*[xciii] a negligence over prescription of a drug resulting in serious necrosis gave rise to a liability ultimately of 45% to the doctor miswriting and 45% to the pharmacist who had not noticed apparently obvious error.[xciv]

From the foregoing, it is evident that, a malpractice disputes arose when the treatment provided by a medical practitioner causes harm or injury unexpected and undesired by the patients. Once this happens, the law has made provision for a number of mechanisms for the settlement of these disputes.

LEGAL MECHANISM FOR THE SETTLEMENT OF MEDICAL DISPUTES

The settlement of medical malpractice disputes by way of a compromise agreement

The first method in the resolution of medical malpractice dispute is by way of a compromise agreement. The law strictly regulates instances in which criminal proceedings may be

discontinued. This includes; "by an agreement between the parties if the law expressly so permits"[xcv], or by the "the withdrawal of the complaint or the civil claim by the civil party who lodge the complaint in respect of a simple offence or a misdemeanor".[xcvi] However, the withdrawal of the civil claim by the civil party who lodged can only be applicable where; the withdrawal is voluntary; the matter has not been heard on the merits, the offence committed does not disturb public order or good morals; in the case of many civil claimants all of them withdraw their complaints or civil claims and where the withdrawal is not as a results of violence, fraud or deceit.[xcvii]

The principle forming the cornerstone of compromise agreement was enumerated in the English case of *Holsworthy Urban District Council v Holsworthy Rural Council*[xcviii] in which it was stated that, the parties in the case may settle their disputes, the subject matter of the litigation without any adjudication from the court. This settlement then is by way of compromise between them and takes effect as a contract. The dispute is thereby disposed of and may not be re-opened in another subsequent action. If the parties want the compromise or settlement of their dispute to have the force of a formal judgement, they may request the court to enter a judgement in the action embodying the terms of the compromise.

In an action for medical malpractice, the general rule is that, damages must be assessed once and for all at the trial as "it is a well settled rule of law that damages resulting from one and the same cause of action must be assessed and recovered once and for all".[xcix] This suggest that, two actions will not lie by one claimant action against the same defendant. The rule that, damages must be assessed once and for all can be illustrated in the case of *Derrick v Williams*[c] where a child was killed by the negligence of the defendant, an action was brought for damages in respect of the death but not for loss of expectation of life[ci]. The action was settled out of court. It was held that, the acceptance of the sum paid into the court in satisfaction of the claim barred a second action for damages for loss of expectation of life.

This principle points to the effect of such an agreement. That is, it disposed of the matter and the case cannot be re-opened in another subsequent action. Put in other words, it provides a finality of the case so much so that, should the victim of the medical malpractice institute another action from the same facts, the medical practitioner can raise the plea of *autrefois*

acquit. In the Cameroonian case of *Ngwa George Mobanjoh v Jan Ndima Joseph and 2 Others*[cii], Evande LJ pointed out that, "This settlement is by way of compromise and takes effect as a contract. The dispute is thereby disposed of and may not be re-opened in another subsequent action. The defendant in this suit shall pay to the plaintiff herein Ngwa George Mobanjoh the sum of 5 000 000 Frs. in total fulfilment of his claim of 20 000 000 Frs. This payment shall discharge the 1st, 2nd and 3rd defendants from any further claim by the plaintiff on the same cause of action." However, not all medical malpractice litigations are settled out of court without adjudication.

The settlement of medical malpractice disputes through the courts

The second method of the resolution of medical malpractice disputes is by way of adjudication through the court. However, for a claim to be entertained in court certain conditions must be met in the commencement of the action and in the running of the court proceedings. Firstly, it is trite law that, a party who commences an action must have the *locus standi* to do so. Secondly, the plaintiff must show that he has sufficient interest[ciii] in the matter and not a mere busy body parading the corridors of the court for the fun of it. Again, the plaintiff must sue the proper court given that, all law suits are either file before the Court of First Instance or in the High Court. Lastly, the applicant must use the right procedure. The proper procedure of a civil matter going to the Court of First Instance, is rightfully commenced by a statement of claim. Whereas, civil matters going to the High Court for a medical malpractice action shall be commenced by a writ of summons (Statement of Claim) given that, the Supreme Court Civil Procedure Rule provide for the use of this method in the most absolute of terms when it states that "every suit shall be commenced by a writ of summons signed by a judge or magistrate or other officer empowered to sign summons".[civ]

The settlement of medical malpractice disputes through the Medical Disciplinary Board

The third method in the resolution of medical malpractice dispute is by adjudicating through the Medical Disciplinary Associations. The disciplinary charge that can be brought before the Cameroon Medical Council against the doctor is that, he was guilty of serious "professional misconduct."[cv] Its jurisdiction is dealt with under the provision of section 41(1) that provides as follows; "The council shall exercise disciplinary jurisdiction at the first instance within the Medical Association. In this capacity, it shall appoint amongst its members a Disciplinary

Board". This suggests that, the Council acts as a trial court of "professional misconduct" actions against a medical practitioner whose action can be appealed against by dissatisfied litigants. It follows from this that private individuals do not have any *local standi* before this jurisdiction.

There are three ways in which the Disciplinary Board may become aware of matters needing their attention in a disciplinary role. A matter may be referred to the Disciplinary Board by the supervisory authority, the legal department or any physician enrolled with the Association who has an interest at stake[cvi]. This points out that, on the doctor's conviction for a criminal offence by a court in Cameroon, the Court Registrar would inform the Disciplinary Board of the fact. This view is gotten from a reading of Section 43 of the 1990 Law that requires that, the "matters that may be referred to the Disciplinary Board include **"**any conviction for professional misconduct."

CONCLUSION

From the discussion above, a number of issues have been brought to the limelight regarding the nexus between medical malpractice and the settlement of disputes. Firstly, that there exists in Cameroon a number of laws, policy standards, guidelines and practices that govern the patient-doctor relationship in the provision of healthcare services. Secondly, that the breach of these rules and regulations infringes the patient's rights to healthcare as well as leads to the provision of substandard medical care that should not go unpunished. Thirdly, the consequences of such a breach are far reaching to both the patient, their families and the society as a whole. As regards the patient, a malpractice of a medical doctor may lead to deformities or personal injuries. Again, their families may suffer from the loss of a bread winner or the spouse may lose the right to consortium. Similarly, a malpractice claim may have the effect of the society losing trust of our health system. Lastly, to resolve any dispute arising due to the medical malpractice of a medical practitioner or health facility, the state of Cameroon has put in place a number of machineries that ranges from out of court settlement to adjudication in courts and disciplinary sanctions provided by the disciplinary board. Given the cost and time factor involved in the settlement of this disputes and it effect on the reputation of the profession, some recommendations are put forward.

People should be educated about their legal rights in the area of medical litigation against all forms of medical malpractices. The moment the people are enlightened as to their legal rights to healthcare, they will be prepared to protect it, not only by seeking for a compromise agreement but also by commencing actions in case of abuse. Courts or judges on their own part should punish promptly and severely all the breakers of the laws governing medical malpractices. This will enable punishment to achieve its most desired objective of deterrence.

Finally, the Cameroon Medical Council should make sure that the ethics of the profession are strictly respected by medical practitioners and defaulters punished so that the reputation of the medical profession is respected by the public and health care users will not lost trust in the medical profession by the use of alternative medicine when sick for the fear that, the hospital has been transformed into a grave yard. If these recommendations are adhered to then, medical malpractice will be reduced drastically.

ENDNOTES

[i] On a comprehensive approach of building patient safety, see Kohn, LT et al (2000), "*To err is human: building a safer health system*," Washington DC: National Academic Press, pp. 1-17.
[ii] Studdert, DM, et al (2006), "*Claims, error, and compensation payments in Medical Malpractice litigation*," N Engl. J Med. 354(19): pp. 2024-33.
[iii] Mann, J. et al (1990). *Human and human rights: A reader*, 1st ed. New York: Routledge, p. 281.
[iv] Danzon, P. (1984), "*The frequency and severity of Medical Malpractice Claims*," Journal of Law and Economics, Vol. 27, pp. 115-148.
[v] Law no. 96/036 0f 10th August 1990 on the Practice of the Profession of Medicine.
[vi] Law Nº 2005/007 of 27th July 2005 on the Criminal Procedure Code.
[vii] Kaveler, F. (2004), "*American First Medical Malpractice Crisis* 1835-1865*,"* Vol. 22, Journal of Community Health, p 100; See further Mohr, J.C. (2000), "*American Medical Malpractice Litigation Perspectives*; Vol. 283, JAMA. p. 7.
[viii] Sir William Blackstone is the first person to have used the word "*medical malpractice or praxis* "in 1769, Blackstone, 3 BI Comm. 122.
[ix] Cox, H.W.C. (2000), *Medical Jurisprudence and Toxicology*, 7th ed., Lexis Nexis Butterworth, p. 77.
[x] Ibid, at p. 55.
[xi] Garner, B.A. (Ed.) (2009), *Black's Law Dictionary*, 9th ed., West Group St. Paul Minn, at p. 959.
[xii] Francis, C.A. (1988), *Medical Jurisprudence and Toxicology*, 21st ed., Tripoli Private Limited, at p. 23.
[xiii] Mackay, B.P.H. (Ed.), (2008), *Halsbury Law of England*, 5th ed., Lexis Nexis, at p. 17.
[xiv] Louise, S. (2001), *Diversified Health Occupations*, 5th ed., Delmar Thomson Learning Publishing, p 57.
[xv] Ibid.
[xvi] Ibid.
[xvii] Henry, E.S. (1996), *The Physician's Profession through the Ages*, 1st ed., MD Publications, p. 3.
[xviii] Per Lord Baron Alderson in *Blyth v Birmingham Water Works* (1856) 11 Ex 781.
[xix] Guptha, J. (2002), "*Ethics and Law Controlling Medical Practitioners,"* Vol. 4, ALR, at p. 305.
[xx] *Bolam v Friern Hospital Management Committee* (1957) 2 All ER 118. On the facts of this cases, Mr. Bolam suffered from a depression and entered a hospital to undergo Electro-Convulsive Therapy (ECT). The practice as the name suggest causes possibly quite severe muscular spasms. The doctor giving the treatment failed to

provide either relaxant drugs or any means of restraint during the treatment. The claimant suffered a fractured pelvis and the question for the court was whether there was negligence in the practice of providing neither restraint nor relaxants. The court received evidence that a number of different practitioners carrying out the type of treatment took different views on the use of restraints or relaxants drugs.

[xxi] This definition has been approved by the House of Lords in *Whitehouse v Jordan* (1981) 1 All ER; (1981) 1 WLR 246; *Maynard v West Midlands Regional Health Authority* (1985) 1 All ER 635; and *Sidaway v Bethlem Royal Hospital* (1985) 1 All ER 643.

[xxii] (466) So. 2d. 856 (Miss. 1985).

[xxiii] The World Medical Association Statement on Medical Malpractice (1992) adopted by the 44th World Medical Assembly in Marbella, Spain September 1992.

[xxiv] Jolowics, J.A. Ellis, L.T. and Harris, D.M. (2010), *Winfield on Torts*, 18th ed., London Sweet and Maxwell Publisher, p. 28.

[xxv] (1955) Times 1–2 November.

[xxvi] The unreported judgment of Arête No. 694/P du Juillet, 1985, Cour d'Appel de Douala.

[xxvii] The unreported judgment of Suit No. HCK/58C/86.

[xxviii] (2002) EWCA Civ 18.

[xxix] CE, ass. 9 Avril 1993, *Bianchi*.

[xxx] Application No. 1513/03; (2006) 42 EHRR 40; See also, *Maurice v France*, (2005) ECHR 679; See the decision of the case of CC, 11 Juin 2010, n° 2010-2 QPC, in which the court held that, the failure to diagnose was negligent.

[xxxi] (1981) 1 All ER 267.

[xxxii] Per Lord Denning in *Whitehouse v Jordan* (1981) 1 All ER 267, p. 361.

[xxxiii] See Cass. 1e Civ. Mars 1 2005, Bull civ. 1 No. 104.

[xxxiv] See Cass. 1e Civ. Septembre 30, 2010, No. 90. 68372.

[xxxv] Cass. 1e civ. Novembre 13, 2008, No. 07, 18008, JCP 2009, 11, 10030, note Pierre Sargon.

[xxxvi] The Times News 25 May 1951.

[xxxvii] (1952) Times 12 November.

[xxxviii] (1987) 2 All ER 909.

[xxxix] The Times News July, 31 1937.

[xl] Arête No. 35/CRIM of 15 June 2011 (Unreported).

[xli] See TPI de Mbouda, judgment No. 14/cor du 6 Novembre 2000, note Rose Djila, jurisdis peroidique, No. 56, Oct. Nov. Dec, 2003, p. 58, pp. 55–60.

[xlii] See Article 2(1).

[xliii] *Wilson v Vancouver Hockey Club* (1983) 5 DLR (4th) 282.

[xliv] *Gascoine v Ian Sheridan* (1994) 5 Med. LR 437 where a consultant gynaecologist was encountered with an unexpected problem of an invasive carcinoma following the operation of a single hysterectomy.

[xlv] *Taylor v West Kent Health Authority* (1997) 8 Med. LR 251.

[xlvi] (1987) WWR 217.

[xlvii] (1996) 7 Med. LR 83.

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

[xlix] *Jones v Manchester Corporation* (1952) QB 852.

[l] *Clarke v Mc Lennan* (1983) 1 All ER 416.

[li] (1981) 1 All ER 267 (HL).

[lii] *The People and Mambo Sonita Fon v Funebe Chritopher* Suit No. CFIB/892C/011 (Unreported).

[liii] Per Kimbeng Glory in *The People and Mambo Sonita Fon v Funebe Chritopher* Suit No. CFIB/892C/011 (Unreported).

[liv] *Parry v North West Surrey Health Authority* (1994) 5 Med. LR 259; See also, *Bowers v Harrow Health Authority* (1993) 6 Med. LR 16.

[lv] (1995) 6 Med. LR 234.

[lvi]Suit No. HCK/14/2001-2002 (Unreported).

[lvii] *Dryden v Surrey County Council and Steward* (1936) 2 All ER 535.

[lviii] (1933) 79 SJ 13.

[lix] (1939) 2 KB 14. See also, *Caldera v Gray* the Times, February 15 1936, where a doctor gave his patient a hypodermic injection for malaria as a result of which he pierced the sciatic nerve; See further *Hucks v Cole* (1968) 118 New LJ 469, where following surgery for the removal of a swelling from the parotid gland under general anesthetic, the claimant was taken to the recovery ward but suffered brain damage caused by hypoxia for a four to five minutes period, which the anesthetist had failed to prevent. Finally, see the case of *Emeh v Kensington and Chelsea and Westminster Health Authority* (1985) Q.B. 1012, where a surgeon performed a sterilization operation on the claimant but she subsequently became pregnant.

[lx] *Taylor v Worcester and District Health Authority* (1991) 2 Med. L.R. 215.
[lxi] The Times February 21 1987.
[lxii] CAA Nancy, 9 Juillet 1991, *Mme Guyot*, n° 89NC00842, Inédit au recueil Lebon.
[lxiii] CE, 5ème et 3ème sous-section réunies, 27 Juin 1997, *Mme Guyot*.
[lxiv] CE, 10 Avril 1992, *Époux Vergos*, *op. cit.*
[lxv] CE, 14 Décembre 1981, *CH de Pontoise / Mlle Matin*, Rec. CE, 1981, Tables, P. 904.
[lxvi] CE, 18 Février 1987, Dame Juyoux, Rec. CE, 1987, Tables, p. 929.
[lxvii] CE, 9 Mars 1988, *Mme Pecke*, Rec. CE, 1988, p. 110.
[lxviii] CE, 11 Mars 1988, *Mme P.*, Rec. CE, 1988, Tables, p. 1007.
[lxix] CE, 14 Octobre 1988, *Martin*, RDSS, 1989, p. 238.
[lxx] CE, 5 Mars 2008, *CPAM des Côtes d'Armor et CH de Dinan*, n° 287136, Inédit au recueil Lebon.
[lxxi] CE, 22 Novembre 1967, *Ciabrini*, Rec. CE, 1967, p. 439.
[lxxii] CE, 6 Octobre 1976, *CH de Châlons-sur-Marne*, n° 96273, Inédit au recueil Lebon.
[lxxiii] CE, 12 Mars 1975, *Hospices Civils d'Haguenau*, Rec. CE, 1975, Tables, p. 1250.
[lxxiv] CE, 21 Mai 2008, *M.A / CH du Havre*, n° 296686, Inédit au recueil Lebon.
[lxxv] Cass. civ. 1ère, 17 Janvier 2008, n° 06-20.568, Non publié au Bulletin.
[lxxvi] CE, 21 Mars 1969, *CHR de Montpellier*, Rec. CE, 1969, p. 950 ; CE, 14 Décembre 1984, *Mlle Quignon*, Rec.
[lxxvii] CAA Nantes, 12 Mars 1992, *Mme Durand/CHR d'Angers*, n° 90NT00026 et n° 90NT00044, Rec. CE, 1992, Tables, p. 1306.
[lxxviii]CAA Paris, 26 Février 1998, *Consorts Savouré /CHR Léon Binet de Provins*, n° 96PA04239 et n° 97PA02207, Inédit au recueil Lebon.
[lxxix] CAA Versailles, 15 Juillet 2009, *M. et Mme X.*, n° 07VE00490, Inédit au recueil Lebon.
[lxxx] Recommendations of the Council of Ministers of Europe, R. 84-2 du 25 October 1984 relating to the prevention of infection in hospitals.
[lxxxi] It is endogenous when the patient is infected with his own germs by invasive action, and infections due to a particular fragility, whereas, it is exogenous when the infection is caused by germs brought by the hospital environment, personnel or other patients.
[lxxxii] CE, 27 Septembre 2002, *Mme Neveu/Centre Hospitalier Intercommunal de Créteil*, Rec. CE, 2002.
[lxxxiii] *Ibid*, p. 315; See also, CE, 2 Fevrier 2011, *M. Arnaud A./CHR d'Orléans*; See further CE, 10 Avril 2009, *Hospices Civils de Lyon/Mlle Marie-Laure A.*, Rec. CE, 2009, Tables, p. 941.
[lxxxiv] CA Rennes, 4 Février 2009, *Clinique Sainte Thérèse*, Juris-Data n° 2009-375814.
[lxxxv] Cass. 1e Civ. Feb 18, 2009, Bull Civ. I No. 37; Actualité Juridique (AJ) 630.
[lxxxvi] CAA Marseille, 13 Avril 2006, *CHU de Nîmes*, n° 04MA01092, Inédit au recueil Lebon.
[lxxxvii] CAA Bordeaux, 11 Mars 2008, *CHU de Bordeaux*, n° 06BX00144, Inédit au recueil Lebon ; see also, the decision of the CAA Lyon, 29 Juin 2010, *CHU de Saint-Etienne*, n° 08LY00653, Inédit au recueil Lebon : that considered the « immune compromise state of the victim » to be an exonerating external factor.
[lxxxviii] *Cassidy v Ministry of Health* (1951) 1 All ER 574.
[lxxxix] (1937) The Tmes July 31.
[xc] (1947) 1 K.B. 598.
[xci] (1952) 2 K.B. 852.
[xcii]Times Law Reports, 14 March 1989.
[xciii]Times Law Reports, 12 November 1983.
[xciv] See Mullon, K. (1988), *"Writing a Wrong,"* Vol. 26, B.M.J., pp. 401–6
[xcv] See 1 Section 62(1) (f) of the Law No 2005/007 of 27 July 2005 relating to the Criminal Procedure Code.
[xcvi] Ibid, Section 62(1) (h).
[xcvii] Ibid, Section 62(2).
[xcviii] (1907) 2 CH 62.
[xcix] Per Browen L.J in *Brunsden v Humphrey* (1884) 14 QBD 191, at p.147.
[c] (1939) 2 All ER 559.
[ci] Abolished by the Administration of Justice Act 1982 S.1.
[cii] Suit No. HCK/3/2009 (unreported).
[ciii] For the test of sufficient, see generally *Hon. Justice Ovie-whysky and Ors v Chief OLawayin and ors* (1985) 5 NCLR 156. *Chief Ojukwuv Governor Lagos State and Ors* (1985) 2 NWLR (p+10) 806 *Prince Madara v Military Governor Oyo State* (1986) 3 NWLLR (p+27) 125
[civ] See generally O. 2 R. 1 of the Supreme Court Rules.
[cv] Section 43 of the Law No 90-36 of 10 August 1990 relating to the Organisation and Practice of Medicine.
[cvi] Ibid, Section 42.