The Impact of the Standard of Care on Medical Negligence in Nigeria and Malaysia

Kome Bona-Idollo
Student, Taylor's Law School
Taylor's University, Malaysia
komeidollo@outlook.com

Anisah Che Ngah
Associate Professor, Taylor's Law School
Taylor's University, Malaysia
anisah.chengah@taylorsedu.my

Saratha Muniandy
Lecturer, Taylor's Law School
Taylor's University, Malaysia
saratha.muniandy@taylors.edu.my

Sivashanker Kanagasabapathy
Medical Director, National Kidney Foundation Malaysia
shanker.kana2718@gmail.com

Abstract

The aim of the medical negligence system, particularly to deter negligent behaviour, has created challenges for both patients and medical practitioners who are major stakeholders in health care. Using the breach of duty requirement, its impact on health delivery can be evaluated using the Nigerian and Malaysian health system. In Nigeria, the patients are seen to be impacted more by medical negligence as the *Bolam's principle* presents the medical expert witness challenge which adds up to the existing challenges of ignorance and poverty. They are then deterred from reporting the negligent act which could go on with indifferent doctors. Also, in Malaysia, medical doctors are more impacted by medical negligence as the *Rogers/Montgomery principle* exposes them to possible litigation which creates fear and causes defensive medicine. This act of defensive medicine deters good health practices. Therefore, these effects on both patients and medical doctors put the health system at risk. Mediation has been seen to be a more feasible option to the medical negligence system as it promotes the doctor-patient relationship which is the basis for healthcare. While Court-annexed mediation is preferred in Nigeria, both private mediation and court-annexed mediation exist side by side in Malaysia. However, there is a need to consider the practice of mediation on a federal level in Nigeria and there should be a

standardised practice for all mediation forms in Malaysia.

Keywords: breach of duty, healthcare, mediation, medical negligence, standard of care

1. Introduction

Nigeria and Malaysia rely extensively on common law. Standard of care forms the bedrock of the tort system in determining a breach of duty. This standard has been criticised to be favourable to the medical practitioners with the *Bolam's* principle[307] and favourable to the patients with the *Rogers/Montgomery test*.[308] Therefore, it could be argued that patients are discouraged from initiating legal action against negligent doctors and medical practitioners tend to act defensively. This has consequently affected both patients and medical practitioners who are an important unit in the health system.

2. Patient's Perspective

In proving breach of duty to treat and diagnose, the *Bolam's principle* is usually the traditional test applied in both Nigeria and Malaysia to determine the acceptable standard. However, *Bolam* has been criticised to provide a cloak of protection around medical practitioners as patients are faced with an insurmountable challenge to show that no responsible body of professional opinion exists that would advocate the course of conduct under question.[309] Although the *Bolam principle* recognizes that medical practitioners keep up with the latest development in their medical specialties,[310] doctors still feel reluctant to officially opine that the conduct of a colleague was actually below the levels that should be expected.[311] This could allow for practices that are detrimental to the health of the patient to continue. It could also hinder medical practitioners from adopting the latest developments and improving themselves as their current conduct is seen as acceptable. This exposes patients to potential substandard health care. The *Bolitho* test which was set to curb the doctor-centric effect still requires some medical knowledge that judges

[307] Vivienne Harpwood, *Modern Tort Law* (Psychology Press, 2005).
[308] Felicity Mills and Miran Epstein, 'Risk disclosure after Montgomery: Where are we going?' (2018) 21 Case Rep Women's Health.
[309] All Answers ltd, 'Is it time to say bye-bye Bolam in medical law?' (UKEssays.com, November 2018) <https://www.ukessays.com/essays/law/is-it-time-to-say-bye-bye-bolam-in-medical-law.php?vref=1> accessed 8 May 2021.
[310] Puteri Nemie Jahn Kassim, *Medical Negligence Law in Malaysia* (ILBS 2003).
[311] All Answers ltd, 'Is it time to say bye-bye Bolam in medical law?' (n 309).

do not have.[312] Therefore, it will be difficult to say a medical expert's testimony is illogical as the medical opinion provided by the expert might still be regarded as an acceptable standard.

In Nigeria where *Bolam-Bolitho* has been predominantly applied for treatment, diagnosis, and disclosure of information, negligence is still on the rise. 61.69% of Nigerian patients feel that doctors are arrogant and care less about their condition and 33.3% of Nigerian patients indicated that their doctors' treatment had caused them extra injury beyond the ones that required them to go to the hospital.[313] Patients are exposed to risks with the high prevalence of late detection of ailments, the mistaken identity of patients, improper and lack of consent to treatment, etc.[314] With all of these, health care providers have been seen to be indifferent.[315] Ignorance and poverty of the Nigerian populace have been majorly attributed to this attitude among health care providers.[316] However, it is suggested that even if these cases go on to the court, the chances of them being seen as negligent are not certain as they could be supported by medical opinion. Therefore, patients are deterred from reporting negligent acts and this could further encourage the indifferent attitude seen among doctors. Subsequently, patients suffer from the negligent acts in silence and eventually lose trust in the care provided.[317] Trust plays a significant role in healthcare as it is central to clinical practice and important for effective treatment.[318] With the negligent incidents commonly experienced in Nigerian public hospitals due to less motivated doctors and limited health resources,[319] patients have lost their trust in the public health system.[320] Private hospitals, although expensive, have now become preferred as they can be trusted with more hospitable treatment and better-motivated doctors.[321] This attracts more health costs for the patients and defeats the affordability factor that quality health care demands.[322]

[312] *Bolitho v City and Hackney Health Authority* [1998] AC 232, 778.
[313] Uwakwe Abugu and Dike C Obalum, 'An Agenda for Improving Legal Claims for Medical Malpractice in Nigeria' (2018) 14(5) Asian Social Science 118.
[314] Ibid.
[315] Felix Chukwuneke, 'Medical Incidents in Developing Countries: A Few Case Studies from Nigeria' (2015) 18 Nigerian Journal of Clinical Practice S20.
[316] Ibid.
[317] Felix Chukwuneke (n 315).
[318] Johanna Birkhauer et al, 'Trust in the Healthcare professional and health outcome: A meta-analysis' (2017) 12(2) PLoS One 1.
[319] I Omoleke and Bisiriyu Taleat 'Contemporary Issues and Challenges of Health Sector in Nigeria' (2018) 5(4) Research Journal of Health Sciences 210.
[320] Felix Chukwuneke (n 315).
[321] Ibid.
[322] Valerie Shelly, Susann Roth and Kirthi Ramesh, 'Universal Health Coverage Must Be High Quality to Improve Patients' Health Outcome' (Asian Development Blog, 11 March 2020). <https://blogs.adb.org/blog/health-care-must-be-affordable-and-accessible-also-high-quality> accessed 10 May 2021.

Similarly in Malaysia, the *Bolam-Bolitho* test being applied to determine the standard for treatment and diagnosis exposes patients to similar risks associated with the 'conspiracy of silence' seen amongst medical practitioners. The Malaysian Medical Council (MMC) has reported that its integrity is in crisis[323] as its members are always looking to protect each other. Even though this was reported in the context of complaints brought before the MMC it can be inferred that this same attitude will be seen among practitioners when acting as medical expert witnesses. Statistics from the MMC and data from the Health Ministry have shown that with 3,500 cases being reported to the Ministry involving wrongful surgery and other medical errors at both public and private hospitals, only about 150 annually make their way to an investigation panel. In 14 years, only 14 doctors have been struck off, 39 suspended and 73 reprimanded. Almost 90 percent are not investigated by the MMC, and disciplinary action is taken in less than one percent.[324] This shows the effect of doctors covering up for each other. Negligence cases are on the rise with the number of incidents between 2016 and 2018 involving wrong surgery, unintended retention of foreign objects (URFOs), transfusion and medication errors and patient falls nearly doubling up in both public and private hospitals.[325] With the failure to hold errant doctors to account, there is a possibility that negligence cases will keep rising and there will be a decline in the standard of healthcare provided. This also raises concerns about trust being lost in the healthcare system.[326]

Societies are now shifting towards being rights-based and promoting an individual's right to fair and just treatment. This has necessitated the public to increasingly expect a consistent and proper method of redress and regulation when systems are shown to have failed them.[327] However, with the breach of duty requirement being insurmountable,[328] it is difficult to show that the healthcare system has failed in order to get the necessary redress. This deprives patients' right to health, which according to the WHO Constitution is attaining the highest standard of health.

Although the *Rogers/Montgomery* tests have been hailed to be patient-centric as it respects patients' autonomy, it is still far from being so. A lot remains in the hands of doctors.[329] The therapeutic exception has been accepted in common law as an exception to the rule requiring the doctor to provide relevant information about treatments to competent patients which is

[323] Murray Hunter, 'Patients Betrayed: Malaysian Medical Council Protects its Own' *Asia Sentinel* (Malaysia, 6 February 2020) <https://www.asiasentinel.com/p/patients-betrayed-malaysian-medical-e17> accessed 15 March 2021.
[324] Ibid.
[325] Murray Hunter (n 323).
[326] Ibid.
[327] All Answers ltd (n 309).
[328] Ibid.
[329] Felicity Mills and Miran Epstein (n 308).

necessary for the consent process.[330] This means a doctor can decide to withhold information if he believes such information will cause the patient serious physical or mental harm.[331] Again doctors can still retain their power and this exemption presents a chance for the negligent act to continue which defeats the patient-centric healthcare the *Rogers/Montgomery* test was set to achieve.

In the recent Singaporean case of *Hii Chii Kok v Ooi Peng Jin London Lucien*,[332] the court extended the scope of the exception in providing relevant information to a patient. The Court commented that the therapeutic exception could be exercised on patients who "though not strictly lacking mental capacity, nonetheless suffered from such an impairment of his decision-making abilities that the doctor would be entitled to withhold the information".[333] This was subject to three conditions - "the benefit of the treatment to the patient, the relatively low risk presented and the probability that even with suitable assistance the patient would likely refuse such treatment owing to some misapprehension of the information stemming from the impairment". The Court exemplified this with "certain geriatric patients" who may be "easily frightened out of having even relatively safe treatments that can drastically improve their quality of life, and whose state of mind, intellectual abilities or education may make it impossible or extremely difficult to explain the true reality to them".[334] The development of this therapeutic exception by the Singaporean Court creates a concern for the patients whose decisional abilities are impaired. According to the conditions, doctors are expected to weigh the probability of informational and other decisional assistance failing before deciding whether to withhold it from the patient. This suggests that doctors do not even have to try providing such assistance if they believe it is unlikely to work.[335] This then contradicts the principle in the Singaporean Mental Capacity Act, 2010,[336] which is similar to that of England and Wales, Malaysia and Nigeria that explains that a person is not to be treated as unable to decide unless all practicable steps to help him to do so have been taken without success.[337] Evidence has shown that patients may have difficulty understanding health information with medical care becoming more complex and driven by technological advancements.[338] This means according to the development in the law, a substantial number of patients could fall into the category of having impaired decisional abilities and they could be

[330] Sumytra Meon et al, 'How the 'privilege' in therapeutic privilege should be conceived when considering the decision-making process for patients with borderline capacity?' (2021) 47(1) Journal of Medical Ethics 47.
[331] Ibid.
[332] [2017] SGCA 38; [2017] 2 SLR 492.
[333] Ibid.
[334] Hii Chii Kok (n 332) 152.
[335] Sumytra Meon et al (n 330).
[336] Mental Capacity Act, 2010, CAP 177A.
[337] Ibid, section 5; Mental Capacity Act 2005 (UK), section 3.
[338] Sumytra Meon et al (n 330).

excluded from making decisions on their treatment thereby trumping their autonomy.[339] With Singapore being a common law jurisdiction as well, chances are that Nigerian and Malaysian courts could adopt this development. Considering the concerns around it, patients could be deprived of good health care.

3. Medical Practitioner's Perspective

The *Bolam-Bolitho* test afforded medical practitioners protection. However, with the development of the law in the *Rogers/Montgomery* test, this protection was removed in regards to the doctor's duty to inform. This has made it more likely for patients to commence litigation either rightly or wrongly believing they have more chances to win.[340]

The reasonable-patient standard which was developed from *Rogers v Whitaker*[341] and the most recent *Montgomery*[342] case expects a doctor to take reasonable care in ensuring that a patient is aware of any material risks involved in any recommended treatment as well as reasonable alternative treatments. The risks were held to be material if 'a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would be likely to attach significance to it'.[343] Informing a patient of the associated risks of treatment requires that the patient should be informed of the benefits as well. Emphasis has been placed on the need to discuss reasonable alternative treatments with patients; however, what makes for 'reasonable' alternatives is far from clear and not much guidance has been provided by the courts.[344] Expecting that every conceivable alternative treatment must be discussed in detail with patients can be argued to be beyond the concept of reasonableness.[345] Proper communication and documentation takes time. Doctors are faced with balancing their various roles as clinicians, educators, scientists, and administrators while also trying to meet the fast patient turn-over and diligent clinical care.[346] In societies like Malaysia where the Health Ministry has been said to be understaffed[347] and Nigeria where there

[339] Ibid.
[340] Ming W Tan, 'Ill Advice or Ill- Advised? Negligent Medical Advice and the Modified Montgomery Test' (2016/2017) 8 Singapore Law Review 1.
[341] (1992) 175 CLR 479.
[342] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.
[343] Ibid, 87-88.
[344] Sarah Devaney et al. 'The Far- Reaching Implications of Montgomery for Risk Disclosure in Practice (2019) 24(1) Journal of Patient Safety and Risk Management 25.
[345] Ibid.
[346] Han Y Neo, 'From Bolam-Bolitho to Modified Montgomery- A Paradigm Shift in the Legal Standard of Determining Medical Negligence in Singapore' (2017) 46 Ann Acad Med Singapore 347.
[347] Sira Habibu, 'Health D-G: Public health care system needs funding boosting' *The Star* (Petaling Jaya, 17 July 2019) <https://www.themalaysianinsight.com/s/231194> accessed 26 October 2020.

are major shortages in human resources because of the ”brain drain” of doctors and nurses,[348] this puts an extra burden on the medical practitioners. Therefore, placing a duty on doctors to disclose the ‘uncertainties’ associated with a range of medical treatments, leaves the precise scope of the legal duty arguably poorly defined and exposes practitioners to potential legal suits.[349]

Additionally, it is expected that family doctors would play an important role in determining what might be considered material information to a patient as they spend more time with the patient.[350] However, it would neither be fair nor feasible to expect clinicians who have not been attending to a patient for a substantial period to be able to predict the patient’s concerns and worries in determining what could be material information.[351] Doctors, particularly surgeons, would often be uncertain as they do not spend substantial time with a patient to be able to know which clinical risks should be disclosed and discussed. This could lead to the surgeon underestimating the implications of a small set of risks on a patient and potential litigation could be impending as there is an avenue for a patient to claim for a breach of duty to inform.[352]

The fear of these potential litigations due to the stigmatisation, loss of confidence, and a possible personal financial toll[353] lead to the practice of defensive medicine among medical practitioners. Even though it might be argued that medical practitioners have the therapeutic exception (TE) as an available defence, TE is vague and poorly articulated, making its application rare and constrained. It has been suggested instead that the vagueness of TE will make it difficult for clinicians to predict whether the Court will consider their decision not to disclose a risk as unreasonable.[354] Therefore, doctors do all they can to avoid a possible legal complication with the practice of defensive medicine.

[348] Komolafe Akinlabi Richard Obafemi, ‘Medical Negligence Litigation in Nigeria: Identifying the Challenges and Proposing a Model Law Reform Act’ (Dphil thesis, Trinity College 2017) <http://www.tara.tcd.ie/bitstream/handle/2262/81835/Download File.pdf?sequence=1&isAllowed=y > accessed 24 October 2020.

[349] Ibid.

[350] Albert Lee, ‘‘Bolam’ to ‘Montgomery’ is result of evolutionary change of medical practice towards ‘patient-centred care’’ (2017) 93 (1095) Post graduate Medical Journal 46.

[351] Ibid.

[352] Ibid.

[353] Adam C Schaffer and Allen Kachalia, ‘Medical Malpractice and the Hospitalist: Reasons for Optimism’ (The Hospitalist, 9 November 2017) <https://www.the-hospitalist.org/hospitalist/article/151624/medical-malpractice-and-hospitalist-reasons-optimism> accessed 11 May 021.

[354] Emma Cave, ‘The Ill-informed: Consent to Medical Treatment and the Therapeutic Exception’ (2017) 46(2) Common Law World Review 140.

Defensive medicine is loosely defined as medical practice based primarily on the fear of litigation rather than on the expected patient outcomes.[355] The cost of defensive medicine is lower than the cost of facing a lawsuit.[356]

Positive defensive medicine involves doctors providing expensive treatments which are non-productive and cause uncalled risks.[357] Specifically, in the duty to inform, the doctor not having a clear understanding of who a reasonable patient might be or what to disclose could over disclose information.[358] Loads of information are provided to the patient in the hope that everything is covered. This practice can potentially result in heightened levels of confusion and anxiety for the patient.[359] Negative defensive medicine on the other hand is when a doctor refuses to treat a patient who has previous complications, patients in critical conditions, and patients who have previously filed a claim against a medical practitioner.[360]

In Malaysia, due to the high litigation rate[361] and obstetrics being a highly litigious specialisation,[362] it has become an avoided area among medical practitioners, especially in the private sector as they have to deal with the high protection coverage on their own.[363] This has led to a rise in workload in government hospitals. For a health system that has been described to be 'understaffed and overworked',[364] more workload could lead to an increased risk of sub-standard maternity care.

In Nigeria, even with the low awareness of patients to institute legal action, doctors still practice an avoidance form of defensive medicine. The Compulsory Treatment and Care for Victims of Gunshot Act 2017 was created to provide that compulsory treatment and care should be given to gunshot victims by hospitals in Nigeria.[365] However, medical practitioners are still refusing to treat gunshot victims in the country because they have been arrested and kept behind bars due

[355] Eric D. Katz, 'Defensive Medicine: A Case and Review of Its Status and Possible Solutions' (2019) 3(4) Clin Pract Cases Emerg Med 329.
[356] Rozlinda M. Fadzil, Asma H. Abd Halim and Ain A. Ariffin, 'Defensive Medicine as a result of Medical Negligence: A Brief Overview' (2018) 2(1) UNTAG Law Review 70.
[357] Ibid.
[358] Barry G. Main, et al, 'Informed Consent and the Reasonable-Patient Standard' (2016) 316(9) Jama 992.
[359] Ibid.
[360] Rozlinda M. Fadzil, Asma H. Abd Halim and Ain A. Ariffin (n 356).
[361] According to the MOH 2019 Report, total cases increased from 93 in 2015 to 106 in 2019.
[362] n/a, 'Obstetricians in Malaysia are quitting' *Asiaone* (Petaling Jaya, 27 July 2015) <https://www.asiaone.com/malaysia/obstetricians-malaysia-are-quitting> accessed 16 December 2020.
[363] Ibid.
[364] Sira Habibu (n 347).
[365] Ebuka Obidigwe 'An Appraisal of the Compulsory Treatment and Care for Victims of Gunshot Act, 2017: Late Precious Owolabi' (*Mondaq*, 08 August 2019) <https://www.mondaq.com/nigeria/constitutional-administrative-law/835070/an-appraisal-of-the-compulsory-treatment-and-care-for-victims-of-gunshot-act-2017-late-precious-owolabi> accessed 22 January 2021.

to mundane things that are within the purview of medical management.[366] This refusal has led to the loss of lives that could have easily been saved. An instance of this was seen in 2019 when a young man during his service as a youth corps member was shot while reporting a clash. He was taken to various hospitals which rejected him and he eventually met his untimely death.[367] One can imagine how much more defensive the medical practitioners will get when they are faced with possible litigation. This could worsen the below-par health system the country is trying to mend.[368]

Therefore, what defensive medicine does is make medical practitioners more motivated by legal risk instead of the medical outcome.[369] This contravenes the doctor's ethical obligation to 'do no harm'.[370] Providing the patient with information or treatment that is of no benefit to him/her or withholding or avoiding care that would potentially benefit the patient is ethically wrong as it goes against non-maleficence.[371] Focusing on litigations clouds the doctor's best judgment and this is not in the patient's best interest.[372]

4. Impact on the Healthcare System

It is usually expected that a health system should be able to provide timely access to high-quality and affordable care and one that also promotes innovation of new tests and treatments.[373] Health care exists to serve patients. Clinicians are therefore obligated to use their skills to advance the health-related interests of patients rather than promoting self-interest.[374] However, the requirements of breach of duty have promoted the self-interest of medical practitioners as there is protection with the *Bolam's principle* and defensive medicine is being practised due to the *Rogers/Montgomery* which puts the patient at risk.

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[366] Kanayo Umeh and Nkechi Onyedika-Ugwueze, 'Police Insist Hospitals Can Treat Gunshot, Stab Victims Without Report' *The Guardian* (Abuja, 14 December 2019) <https://guardian.ng/news/police-insist-hospitals-can-treat-gunshot-stab-victims-without-report/>accessed 22 January 2021.

[367] Ebuka Obidigwe (n 365).

[368] Oscar Lopez, 'Nigeria's Health care System on the Mend' *U.S News & World Report* (19 September 2019) <https://www.usnews.com/news/best-countries/articles/2019-09-19/nigeria-slowly-improving-its-health-care-system> accessed 19 February 2021.

[369] Eric D. Katz (n 355).

[370] Johan C. Bester, 'Defensive Practice Is Indefensible: How Defensive Medicine Runs Counter To The Ethical And Professional Obligations Of Clinician' (2020) Springer Nature 1.

[371] Ibid.

[372] Vera L Raposo, 'Defensive Medicine and the Imposition of a More Demanding Standard of Care' (2019) 39(4) Journal of Legal Medicine 401.

[373] n/a, 'Judging Health Systems: Focusing on what Matters' (Harvard T.H Chan School of Public Health, 18 September 2017) <https://blogs.sph.harvard.edu/ashish-jha/2017/09/18/judging-health-systems-focusing-on-what-matters/> accessed 8 May 2021.

[374] Rozlinda M. Fadzil, Asma H. Abd Halim and Ain A. Ariffin (n 356).

Proper treatment has become difficult to access as there is a chance that a breach cannot be proven and the negligent act continues. Defensive medicine which involves unnecessary tests/ information brings about wastage of time, depleting resources, and mismanagement of hospital facilities.[375] This results in health care services being faced with a downward spiral and patients are denied access to quality health care.[376] In certain situations, it could lead to loss of lives that the healthcare system aims to preserve. The journal of the American Medical Association released a statement that annually, almost 12,000 patients die from surgeries that were not needed.[377] Additionally, the ethical principle of justice is violated as time, money, and resources are spent where it is not needed which strains the availability of resources where it is needed. The unnecessary or negligent care provided drives more spending by patients which increases societal healthcare costs.[378]

The prudent patient test which was set to promote the autonomy of patients and encourage shared decision making is now practised over zealously out of fear of litigation, thereby defeating its purpose. Consent forms are now made more intricate and detailed, with every possible risk and alternative listed on the form. This poses the danger of consent not being viewed as a shared decision-making process, in which the patient should be encouraged to participate. The dialogue between doctor and patient which should help build trust is missing which makes the patient reluctant to provide important information that could help facilitate treatment.[379] Therefore, best practices are not being carried out as intended and this does not encourage more innovation. The healthcare system is then exposed to less development, thereby affecting its effectiveness and efficiency.[380]

Additionally, doctors refusing to treat a patient out of fear of litigation prevents the patient from benefiting from healthcare.[381] It also creates more workload for the existing health system which could affect the provision of the health needs of patients.[382]

The breach of duty requirement creates an opportunity for more negligent acts to continue and negatively impacts the accessibility, affordability, and availability of quality healthcare available

[375] Ibid.
[376] Rozlinda M. Fadzil, Asma H. Abd Halim and Ain A. Ariffin (n 356).
[377] Ibid.
[378] Johan C. Bester (n 370).
[379] Sarah Devaney, et al (n 344).
[380] Leighann Kimble and Rashad M. Massoud, 'What Do We Mean by Innovation in Healthcare?' (2017) 1(1) EMJ Innov 89.
[381] Ebuka Obidigwe (n 365).
[382] n/a (n 362).

for patients in both Nigeria and Malaysia. Patients' outcomes are diminished, and the aim of a good healthcare system is not achieved.

5. Conclusion

Law creates an opportunity to improve health care by regulating the standard of care provided. However, it does not seem to achieve this purpose. The fault-based system puts the burden on the patient to prove that the care provided was below the acceptable standard. The requirement to prove this presents overwhelming challenges which have made substandard health care remain unreported and patients continue to suffer in silence.[383] This hinders the accessibility to quality health care. On the other hand, an increase in litigation does not improve the standard either, instead, defensive medicine has become the result. This has led to medical practitioners avoiding certain treatments and patients, or carrying out unnecessary tests at the expense of the patient's safety. Patients' outcomes are then diminished, and the aim of a good healthcare system is not achieved. Considering this, it is logical to consider alternative mechanisms.

It is recommended that more attention be given to the mediation system in both Nigeria and Malaysia. To achieve this, it involves the major stakeholders being adequately equipped with the essential knowledge and resources.

In Nigeria, seeing the need to empower patients on their medical rights, a court-annexed mediation system is recommended. However, a federal approach is essential in adopting the system. Mediation laws, rules, and guidelines should be enacted and enforced nationally to promote uniformity in the process. Lagos state mediation laws and rules can be used as a basis for the creation of these national rules and laws. It is expected that this will attach more seriousness to the mediation process. Mediators' accreditation which focuses on essential mediation skills should be standardised and continuing professional development should be made mandatory.

In Malaysia, it is recommended that both private mediation and court-annexed mediation should be made available as a choice. It is expected that while private mediation creates a safe environment for doctors, the court-annexed mediation could also instil fear when needed. To carry out both mediation forms, a standardisation of the laws, rules, and guidelines is also necessary. The Mediation Act 2012 which is already in practice for the private mediation process should also be applicable for the court-annexed mediation. Also, the code of conduct issued by the Malaysian Bar for private mediation could be used as a basis to create a standard that will be

[383] Felix Chukwuneke (n 315).

required of all mediators in Malaysia. Also, the accreditation of judicial officers and judges should be made more formal as seen with private mediators to allow for consistency with the practice in both forms of mediation.

Additionally, the medicolegal curricula in both law and medical schools in Nigeria and Malaysia should focus more on the process of mediation instead of the malpractice system. It is expected this will adequately equip both lawyers and doctors with the comprehensive knowledge needed to be involved in a mediation process for the promotion of the doctor-patient relationship.

Also, educating patients is still needed to make sure they are aware of the benefits that mediation brings in promoting their medical rights and improving their access to quality health care. This education should also clearly include the differences between the court system and court-annexed mediation.

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