TOWARDS A LEGAL REGIMEN FOR THE TRANSPLANTATION OF HUMAN ORGANS IN NIGERIA.

Prologue
The inaugural lecture, I have been made to understand by my seniors in academics, marks the full blooming of the Professor. During the lecture, the whole world is informed of the arrival of the new Professor who also proposes a toast in about one hour or thereabout to the town and gown professing his views on his chosen topic.

My own case is slightly different. By no means can a Professor of eleven years be regarded as new. After my elevation to that esteemed rank, the zeal to present my inaugural lecture was dampened by the long queue of colleagues who were not ready to present theirs and I could not present before them by the ethics of the ivory tower. That zeal was totally extinguished in 2005 when I lost my father and the anticipated euphoria fizzled away. I looked forward to his presence at the ceremony because he was as constant as the Northern Star in my life and stood with me spiritually and physically like the rock of Gibraltar in all my areas of endeavour.

Traditions on the inaugural lecture vary. In some universities, in Europe particularly, the lecture is delivered on a round table to fellow Professors, some academic juniors and the population of invitees is much less than what we have here today. In the African culture the achiever does not celebrate alone. Just as forlorn occasions are shared with neighbours and friends, so are joyful moments shared with friends, and all. It is part of this tradition that we are fulfilling today.

I pray that celebrations of joy shall never cease in our households in Jesus’ name. I had the opportunity of reading the following words at a Barrister’s cenotaph in London; “Here lieth a lawyer, when he lieth no more, he lieth”. The meaning of this is that the person interned in the tomb at that cenotaph was a lawyer. When he could not tell lies again, he simply lied down. Well, that lawyer lies there and perpetually too. Our clergymen here present may contact me in case they can raise him from the dead.

This epilogue on the cenotaph represents the view of people generally on lawyers. I decided to veer a little from the complete umbra of law in coming to the title for today so that you may be convinced that lawyers contribute to social engineering
and scientific development.

I am an avid consumer of the works of Shakespeare and our own Oluwole Akinwande Soyinka otherwise known as Wole Soyinka. Follow me with the words of “Dick the Butcher” in Henry VI part II. He said, “the first thing we do, lets kill all the lawyers.” This disdain is morbidly exhibited by Hamlet at the graveyard when he held up the skull of a lawyer and asked Horatio: “where are his guiddies now, his guilties, his lassies, his tenures and his tricks?”

It is for this reason and more that I decided to venture into a research area that brings law into a tangent with other professions. In this case, medicine. Let me hope that your views about the lawyer will change after this lecture.

Mr. Vice Chancellor, distinguished audience, permit me to give you my opinions on some of the issues here today.

1.0 Introduction
The world has witnessed new advancements in medical science and practice relating to organ transplant, genetic engineering, in-vitro fertilisation and gestational surrogacy, clinical trials, among others, which have been desirable for either restoring or improving the health of patients. Treatments that require transplantation are usually the last resort/hope for the patients. The transplantation of organ from a living or dead person in need of transplantation has become a global practice which is often justified on grounds of its benefits to patients. I shall exclude biological tissues for the purpose of this lecture.

The principal parties in a transplantation exercise are the donor (the owner of the organ), the donee (the person into whom the organ is being transplanted), and the medical doctor or surgeon.

Transplantation of an organ from one person to another has become a global practice which is often justified.

In spite of new breakthroughs, innovations and techniques in medical practice and the fast pace of medical research, Law has been slow in responding to these novel frontiers.

In this context, Law is not referred to as a discipline but is seen in terms of legislation which is the business of us all either as members of the legislature or just casual
individuals. The consequence is that, in the absence of legal control or regulation, practitioners do function outside the terrain of law. For instance, the clinical trials by Pfizer Incorporated in Kano, Northern Nigeria, for a drug meant for the treatment of cerebrospinal meningitis which were carried out in 1996, resulted in the death of eleven children while dozens suffered varying degrees of disabilities. In the ensuing legal battle, medical experts claimed that the trials were in violation of ethical rules for the conduct of medical experiments in human beings. Through their Lawyers, Pfizer Inc. pivoted its defence on the ingenious fact that there was no Nigerian law or regulation requiring ethical committee approval before conducting clinical trials. Therefore there was no need to seek for what the law did not require and neither could they be sanctioned for what the law did not declare as illegal. This is a serious indictment of the Nigerian legal system, a situation that had to be remedied by a specific code, the Code of Ethics, Rule 31 guiding physicians in biomedical research involving human subjects, which came into force in January 2004.

Organ transplantation is with little or no regulation and this requires that specific ethical standards be put in place by the regulating bodies which must be within the ambit of the law. Transplantation of organs, such as kidney and liver which were hitherto all carried out abroad is now carried out in Nigeria, albeit without legal control, resulting in the practice and activities in these areas not being regulated specifically by law but are rather subjected to the ordinary rules of general surgery. These new frontiers in medical knowledge and practice give rise to new issues relating to transplantation, consent, procurement, commercialisation, organ banking, and so on which practitioners have to face and resolve from time to time. This brings up the imperative of a legal regime.

Since law is one of the means of controlling medical practice, it is desirable that issues in respect of organ transplantation be resolved within the confines of the law. Although law may not provide adequate and comprehensive response to all new issues posed by organ donation/transplant, its control may nevertheless be necessary in the interest of the public. While the interest of the public appears to be important, it has to be weighed against the interest of the donor who could be either dead or alive. Where he is dead, the medical practitioner will be dealing with a cadaver which can only express its wish through relations and next of kin. The complexity that emerges in this respect is where the dead person made no will or wish as to whether any of its parts could be used for transplantation, that is, to save
the life of another person on the precipices of death except he takes advantage of the replacement of an ailing organ. There is a myriad of interests to protect in this respect.

There is that of the dead person whose body, although lifeless, deserves dignity in treatment. Ancillary to this is the respect to the wishes of the dead person as to what to do with the totality of his/her. Yet another interest is that of the donee who in this case has the right to privacy and dignity as well. In the case of living donors, their interests against coercion and intimidation exist for protection. Put in a different way, their constitutional rights to liberty, privacy, dignity and freedom of conscience and thought are put on the line. There is also the interest of the law to guarantee health and protection of the citizens. This is a paramount duty of the law to the citizens in any jurisdiction.

It is imperative for a legal machinery to be provided for the control of medical practice which will provide a benchmark and give law its continued duty of protecting the public. Continuous development of medical technology has made it easy for patients to live significant lives after organ transplantation operations.

2.0 Medical Practice

The practice of medicine reflects a symbiotic existence between that discipline and other disciplines. These include philosophy, culture, sciences, politics and most importantly, law. In this relationship, there are usually conflicts. As regards philosophy, an evident bearing is made on morality, which to date, has a strong influence on medical practice. For instance, various situations occur that create conflicts between morality and medicine. The case of euthanasia readily comes up in this respect. The practitioner is placed in a dilemma between morality (assisting the patient to die instead of suffering) and medicine (providing the requisite care while the patient is still breathing). Another example in this respect is abortion. In this instance, the important issue is whether a medical practitioner may carry out an abortion on a patient and under what circumstances. A most polemic instance is whether the medical practitioner could terminate a pregnancy in life-saving circumstances or when there is a foetal defect. The argument amplified by Blackstone (1:121) still exists that life begins in the contemplation of the law as soon as the infant is able to stir in the mother’s womb.
The clash between law and morality occurs where there are the two options of removing a life-threatening foetus in order to save the life of the living person or leaving the foetus in order to protect it. This conflict is usually difficult to settle. One thing is however clear: the medical practitioner has the ethical duty of providing care to the patient, in this case, the pregnant woman.

In the case of science, the medical practitioner is confronted with the emergence of new methods and drugs. Drugs must undergo clinical trials before they are recommended by medical practitioners. The conflict comes up on who bears the consequences in case the clinical trials end up having negative effects.

As for culture, that provides a more complex result. In some cultures, women are not allowed to interact with men freely and indeed, they are kept in confines. If this culture is taken strictly, female patients cannot be attended to by male medical practitioners and vice versa. Notwithstanding this, the medical practitioner has an ethical duty to care for the patient.

In some cultures, the body of a dead person must not be desecrated. In this situation, such a culture will not approve of the removal of a body organ from a dead person for research or transplantation purposes. This is a norm imposed by the society’s sense of morality.

Ethics are rules of conduct established by interest groups or associations. Most professions have enforceable codes for their members. These codes, for instance in the case of medicine, have antiquated existence. This will be shown shortly in this lecture in our discussions on the Hippocratic Oath in medicine. The word ethics takes its root from the Greek expression ‘ethikos’, a word which signifies ‘custom’ or ‘usage’. From this, it would appear that ethics is a subject matter in philosophy, sociology or in some aspects, anthropology but not Law.

As an aspect of philosophy, it assists in the study of values like right, wrong, justice and responsibility among others. Put in the light of a profession, it includes values in practice relating to what is right, wrong, just and indeed what can give the public confidence in the practitioners of the profession.
Ethics do not have the status of laws in terms of legislative creation. For this reason, such values that constitute the ethics of a profession do not have legislative sanctions. For instance, if an ethical code is broken, there is no possibility of state sanctions like imprisonment, fines or other forms of punishment.

Generally, failure to comply with a code of professional ethics may result in suspension or expulsion from that profession. Even at that, the legal procedure of a quasi-trial must have been fulfilled. The rudiments of this start with the fair trial of the derelict. For instance, in the medical profession, if a medical practitioner is unable to help his patient in his malady, he has an ethical responsibility to refer him to a specialist. The law became clear on this by the recent promulgation of the National Health Act, 2014.

On the other hand if an automobile accident patient is brought to a medical practitioner with serious loss of blood, it would be unethical for the practitioner to refuse to administer blood drips on him. If the patient dies of loss of blood, the medical practitioner may face the Ethics Panel which, after examining the matter and giving him a fair trial, may suspend or expel him from the practice of the profession or exculpate him entirely from the allegation depending on the circumstances.

The strength of ethics is its ability to provide some measure of internal cohesion among its adherents which guarantees compliance and fulfilment of the ethical values. Its weakness is mainly in its lack of statutory or state sanction. Happily enough, some of the ethics in the medical profession have been transformed into law in the National Health Act, 2014. Examples of these are many. The ethics of communication between doctor, and disclosure of confidential information of a patient are just two of the many new innovations into medical jurisdiction on this matter.

Law appears to provide a stabilising effect on all these by providing control on various aspects of practice of medicine. For instance, there are statutes regulating medical practice in all jurisdictions. In Nigeria, some of the statutes include;

a. Medical and Dental Practitioners Act M8 Laws of the Federation of Nigeria 2004
b. Nursing and Midwifery Act Cap N332 Laws of the Federation of Nigeria 2004
c. Pharmacy Act Cap P357 Laws of the Federation of Nigeria 2004
d. Radiographers Registration Act Cap R386 Laws of the Federation of Nigeria 2004
Each jurisdiction attempts to have a set of standardised criteria relating to the practice of medicine, protection of the person, physical integrity of the patient and healthcare generally. All these had existed as far back as the ancient civilisation in Africa, Greece, and Rome, when there was no fixed regime for medical practice.

Medical education, curriculum and practice have varying contents all around the world. This notwithstanding, for a person to qualify to practice as a medical practitioner, he/she must have been admitted to a medical school, and would pass through supervision in practice which is usually referred to as ‘housemanship’.

Plato (270:c-d), while admitting that his sources were imperfect, posited that medical curriculum commenced from composed medical lectures to less technical demonstrations indebted to the methods of the sophists which covered a wide range of medical themes and topics. Plato recorded that Hippocrates interpreted the human frame as an interrelated organism from which he (Hippocrates) founded his medical theories. These theories have greatly influenced medical curriculum through time all over the world.

Eliya et al give the impression that early records of evidence of Medical Practice were discovered in Egypt in the third millennium BC. From this discovery, studies portray Imhotep, the Egyptian as the first physician in history known by name while earliest records of dedicated hospitals were found in Mihintale, Sri Lanka, where archival medicinal treatment facilities for patients were found.

Various social and legal systems evolved a similitude of standardised proceedings and ethos relating to the protection of the health of the population. It is safe to submit that these created the pivot for the control of medical practice in contemporary times. The acknowledged father of medicine, Hippocrates (460-377 BC) provided a set of principles for medical practice which today, form the basis of the oath taken by every medical practitioner without which such a person cannot practice. It is commonly referred to as the Hippocratic Oath. It stated as follows;
“I swear by Appollo Physician and Asclepius and Hygienia and Panaceia and all the gods and goddesses, making them my witness, that I will fulfil according to my ability and judgment this oath and this covenant. To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art as if they desire to learn it without fee or covenant; and to give a share of precepts and oral instruction and other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else. I will apply dietetic measures for the benefit of the sick according to my ability and judgement; I will keep them from harm and injustice. I will neither give a deadly drug to anybody if asked for it nor will I make a suggestion to this effect. Similarly, I will not give a woman abortive remedy. In purity and holiness, I will guard my life and my art. I will not use knife, not even on sufferers from stone, but will withdraw in favour of such men as are engaged in this work. Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relation with both female and male persons, be they free or slaves. What I may see or hear in the course of the treatment concerning the life of man, which on no account must spread abroad, I will keep to myself holding such things shameful to be spoken about. If I fulfil this oath and do not violate it, may it be granted to me to enjoy life and art being honoured with fame among all men for all time to come: if I transgress it and swear falsely, may the opposite of all these be my lot”.

This oath is notable for its covenant to respect, and if necessary teach other members of the physicians’ profession with emphasis on the teacher and the pupil.

The permanent feature of this oath is its insistence upon standards of medical practice and upon the physician’s responsibility to his patients, their families and to the community in general. It laid the foundation, not merely for the knowledge, but for the ethics of medical practice which have grown in the course of time and it underscores medical practice even today.
A contemporary and more concise version of this oath is the Geneva Declaration which was adopted by the General Assembly of the World Medical Association, September 1948. It reads thus;

“I solemnly pledge to consecrate my life to the service of humanity, I will give to my teachers the respect and gratitude which is their due. I will practice my profession with conscience and dignity. The health of my patient will be my first consideration; I will respect the secrets which are confided in me, even after the patient has died, I will maintain by all means in my power, the honour and the noble tradition of the medical profession. My colleagues will be my brothers; I will not permit considerations of religion, nationality, race, party politics or social standing to intervene in my duty and my patient, I will maintain the utmost respect for human life from the time of conception. Even under threat, I will not use my medical knowledge contrary to the laws of humanity. I make these promises solemnly, freely and upon my honour”.

Admittedly, this oath is meant to direct medical practitioners to maintain acceptable professional standards in the course of their practice. Medical ethics started with Hippocrates and his oath. In contemporary times, it covers an unimaginable range of issues in healthcare and related fields, especially the study of moral values as they apply to medicine.

This range of issues include but is not limited to the following broad topics; physicians’ paternalistic role; deceptions and violations of patient confidentiality; the rights of patients or their surrogates to refuse life sustaining treatments or request assistance in dying; drug experiments on children; demented or dying patients; and other incompetent or desperate patients; bias-free definition of health; death; disease and futility of treatment; removing viable organs from patients who are brain-dead or in cardiac arrest; grounds for foetal test; selection and abortion; involuntary hospitalization and treatment of mentally disturbed persons; conflict of interests between physicians and their employers and third-party payers, public and private.

3.0 Historical Overview of Transplantation
Jacques Louis Reverdin, a Swiss Surgeon, successfully performed the first operation of skin transplantation in 1869 while Edward Sirm, a medical doctor performed the first corneal transplant. The first living kidney transplant was performed in 1954 by Joseph
Murray and John Harrison, both of them at that time, surgeons at Peter Bent Brigham Hospital, Boston, while the first cadaveric kidney transplant was performed at the same Hospital in 1962. In Africa, the first heart transplant was performed in South Africa by Dr. Christiaan Bernard on a certain Louis Washkansky, in 1967.

![Louis Washkansky and Christiaan Barnard](image_url)

**Table 1**

The pioneer kidney transplant in Nigeria was carried out in 1999 at the University College Hospital, Ibadan. After this, Teaching Hospitals with facilities for kidney transplant in Nigeria have increased. They include the Obafemi Awolowo University Teaching Hospital, Ile-Ife, Ahmadu Bello University Teaching Hospital, Zaria, Bayero University Teaching Hospital, Kano and lately St. Nicholas Hospital, Lagos. In fact, St. Nicholas Hospital, Lagos was the first private hospital in Nigeria to successfully carry out paediatric kidney transplantation in Nigeria.

Organ transplantation has become a life-saving procedure for many disease conditions hitherto considered incurable. The effects are manifold. The most glaring is that it prolongs life and assures better quality life in nearly helpless situations (Fadare and Salako, 2010:87-91).

There is little data on cases of transplantation surgeries in Nigeria. The reason for this could be lack of technology, workforce and organs. Fadare and Salako (2010:90) note that in Nigeria, just over hundred kidney transplants have been carried out in a limited number of centres. There are no comprehensive records of transplantation of other organs in Nigeria.

### 4.0 Procurement of Organs

An organ in a human being refers to a part of the body that has a particular purpose, such as the heart or the brain (Sokefun, 2004:19-27). From this definition, it is easy to
deduce that an organ, to be so referred to, must have a specific purpose and function in the body. It is different from a tissue which Berube (2004:5) aptly defines as an aggregation of morphological similar cells and associated intercellular matters acting together to perform certain specific functions in the body. These include the skin, muscles, bone and stem cells among others.

Section 64 of the National Health Act of 2014 defines an organ as any part of the human body adopted by its structure to perform any particular vital function including the eye and its accessories, but does not include skin and appendages, flesh, bone, marrow, body fluid, blood or gametes.

Mr. Vice Chancellor and my distinguished audience, if I have your kind indulgence, from this moment, all references in this lecture to an organ shall admit of the exclusion of section 64 of the National Health Act of 2014.

Authors are generally agreed on some major characteristics of an organ (Bakari et al, 2012:53-60). An organ being a part of the body must, for the well-being of the body, operate in harmony with the other organs of the body. For instance, the heart, whose main duty it is to pump blood through the body must operate in harmony with the liver whose main function is to produce the cells that eventually produce the blood. By this same line of argument, the pancreas, for the same purpose in the body, must operate in a way that it would control the sugar level in the system, failing which there may occur an incidence of pancreatic disorder referred to as *diabetes mellitus*. The retina, an organ in the eye sends light rays signals to the brains which in turn relay the signals to the lens. The lens produce the image and with this, the eye is able to see and interpret images. In all these operations, the retina, lens and brains rely on blood pumped from the heart, purified by the kidney, produced by the liver and transported by the veins.

In view of all the above, we shall suggest the definition of an organ as a structural and independent unit in a human being for a specialised function but operating in harmony with other organs of the body. In other words, there is a symbiotic existence among organs in the body.

All organs perform important functions in the body. For various reasons, it might be imperative and expedient to replace an organ. The reasons include but are not limited sub-optimal functioning of an organ, injury, preventive measure against anticipated malfunctioning of an organ and in extreme cases, irreversible failure of an organ.
The transfer of an organ from one human being (dead or living) to another is referred to as transplantation.

5.0 Transplantation
Kanniyakonil attempted four types of transplantation of organs as follows; autograft, homograft, isograft and xenograft. The writer in further discussing this issue noted that autograft is the transplanting of an organ within the same individual from one part of the body to another while isograft is the transplantation of organs between two genetically identical individuals, such as identical twins. She also notes that homograft is the transplantation of an organ from one individual to another within the same species while xenograft is the transfer of organs from animals to human beings. From Kanniyakonil’s presentation, it can be distilled that autograft, isograft and homograft involve transplantation of organs between human beings while xenograft involves the transplantation of organs from animals to human beings. This means transplantation of organs from one specie to the other.

Section 57 of the National Health Act of 2014 assumes donation of an organ through a Will or document. Section 58(4)(a) of this Act goes on to provide as follows;

‘A person who is competent to make a will may:
   i. in the will or
   ii. in a document signed by him and at least two competent witnesses or
   iii. in a written statement made in the presence of at least two competent witnesses, donate his or her body or any specific tissue thereof to be used after his/her death.

This section provides the basis for a testamentary donation of a body organ under the Act.

Procurement of organs from living sources, even when they are minors, does not pose legal challenges unlike some cases in cadaveric procurement. The reason for this is not far-fetched. The living source has the opportunity of giving express consent.

This is not obtainable in cadaveric situations although consent might be discerned from documents like a Will or single document on wish from a person on how to treat his cadaver when he eventually passes on. In terms of the cadaveric source, the testamentary wish of the dead person just before his death could also form the basis for
procurement consent. The relations may however choose not to obey such wish.

There are factors which affect procurement. These are medical and perhaps, scientific. Along these lines, Abouna (2003:61) noted that donor evaluation, both medical and psychological, must be carried out in accordance with accepted protocols and that the consent of the donor must be received before procurement is finalised. This can only be enforce in live donations.

The process is deeply technical, complex and intricate and could end up being counterproductive if not fatal. We shall adopt the determining factors for the transplantation of organs outlined by Davis and Wolitz (paper 5) as follows:

a. blood types of donor (and potential recipient)
b. histocompatibility, that is, the degree of match between the procurement match and the recipient.
c. the degree to which both the donor and recipient are sensitized
d. size and condition of the donor organ
e. age of the donor
f. classification of the urgency of the need of the organ
g. the length of time the potential recipient has spent on the waiting list
h. the distance between the potential recipient’s location and the owner of the organ to be procured (the donor)
i. whether the recipient had donated an organ before then.

Blood type is a key factor in the process of transplantation. For this reason, they identify the four major types of blood as A, B, AB and O with each type containing a rhesus factor that is either positive or negative.

Procurement for transplantation depends on compatibility between the recipient and donor blood types.

The compatibility diagram below shall be explained after the diagram.

**Compatibility diagram**

<table>
<thead>
<tr>
<th>Donor Blood Type</th>
<th>Recipient Blood Type</th>
</tr>
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<tbody>
<tr>
<td>O</td>
<td>O</td>
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<tr>
<td>A or O</td>
<td>A</td>
</tr>
<tr>
<td>B or O</td>
<td>B</td>
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<tr>
<td>A,B,AB or O</td>
<td>AB</td>
</tr>
</tbody>
</table>
From this diagram, it is clear that organs can be procured from persons with blood type O for transplantation in potential recipients with blood type O. However, organs can be procured from an O blood type donor for transplantation in a recipient of any blood type. In other words potential recipients with O blood type have fewer chances of procuring organs for the purpose of transplantation.

In terms of histocompatibility, the human leukocyte antigen (hla) plays a critical role. There are six different hlas with ranking on mismatch scaling from O to 6. The lower the scale, the higher the chances of compatibility of the organ to be procured with the recipient.

Some of the issues raised by Davis and Wolitz are likely to be mitigated by procurement from blood relations for pedigree reasons, when they are willing to donate either when they are alive or as provided in section 57 of the National Health Act, 2014. Of importance is the degree to which the donor and recipient are sensitised. By this, we mean that the donor must be aware that he is making a donation of his organ in order to sustain the life of another person and the recipient must be aware that an organ in his body is being replaced by another from another person’s body. The age of the donor is also important. This is because when it is a minor that is involved, consent takes a difference dimension.

While the issue of sensitisation cuts across all age strata, the age of the donor may present some complexity. For instance if an organ is to be procured from a minor, the parents must be sensitised and must give their consent. Without this consent, legal issues may arise.

The issue of classification of urgency and length of time of wait are also important. In extreme and urgent cases of need for an organ, procurement becomes an issue of emergency with the only determining factor of blood groups and histocompatibility playing important roles and length of time playing lesser role. Where for instance, there is acute haemorrhage due to injury from an accident, procurement would be from any source provided the blood group is the same and the chances of mismatch in histocompatibility are nil or nearly nil.
For the fact that the use of a procured organ for the purpose of transplantation is
determined by the blood type, rhesus and histocompatibility, it can be safely concluded
that these criteria play the most important considerations in the procurement of organs.

6.0 **Consent to Donate**

The consent of an adult who is competent is required for a surgery more particularly a
surgery to remove an organ from the body. Consent as an important factor in this
scheme of things has its criteria. The issue of consent is well articulated in Section 58 of
the National Health Act allows a testamentary consent by a person for the removal of
his or her organ.

a. mental and legal capacity to make the decision

b. consent without duress, undue influence and any form of coercion or
misrepresentation

c. availability of sufficient information on the proposed surgery to ground a decision

These criteria are in tandem with Dworkin’s (1970:353) four infallible conditions for
surgery which include organ removal and replacement.

The conditions are;

a. full, free and informed consent of the patient

b. the operation must be therapeutic

c. lawful justification

d. a person with appropriate medical qualification must perform the operation.

This last condition is a *sine qua non* for any surgical operation. Section 303 of the
Nigerian Criminal Code (cap C38 Laws of the Federal of Nigeria, 2004) is squarely on
this issue. It provides that ‘it is the duty of every person who undertakes to administer
surgical or medical treatment to any other person, or to do any other lawful act which is
or may be dangerous to human life or health, to have reasonable skill and to use
reasonable care in doing such act; and he is held to have caused any consequences
which result to the life or health of any person by reason of any omission to observe or
perform that duty’

In terms of giving consent in guardianship matters, a guardian can give consent on a
ward or a parent on a child who is still a minor. The Declaration of Helsinki (World
Medical Association) adopted at the 41st Word Medical Assembly, Hong Kong in 1989
states in its Basic Principle 11 that in case of legal incompetence, informed consent
should be obtained from the legal guardian in accordance with national legislation.
Where physical or mental incapacity makes it impossible to obtain informed consent or when the subject is a minor, permission from the responsible relatives replaces that of the subject in accordance with national legislation. Whenever the minor child is in fact able to give consent, the minor’s consent must be obtained in addition to the consent of the minor’s legal guardian.

In *Strunk v. Strunk* (455 SW 2d 145 (1969)), the Court of Appeal of Kentucky gave judicial support to a kidney transplant from a certain 27 years Old Jerry whose mental aptitude was of age of six, to his brother after hearing psychiatric evidence of the ‘extremely traumatic’ effect his brother’s death could have upon him. This decision was adopted in *Re Y (Adult Patient)* (1996) 35 BMLR 111 Family Division) where the court held inter alia that it was for the benefit of Miss Y, a 25-year old woman who had suffered from mental infirmity from birth, to donate bone marrow to her sister. The court reasoned that doing so would prolong her positive relationship with her mother and foster better relationship between herself, her sister and her mother. Although not on transplantation, the Nigerian case of *Okekearu v. Danjuma* (2002) 15 NWLR (Pt. 79) 659 gives an impression of the mind of the judiciary if a matter on consent to donate an organ arises. In that matter, the surgeon did not obtain the requisite consent before amputating a badly injured finger of a 14-year-old patient. He was found liable in assault and battery.

Some authors have attempted to create a dividing line between living related donors and the living unrelated donor. It is submitted that the Dworkinian criteria apply squarely in both cases. In fact, there is no known authority to the effect that a living person is under any duty to donate to a relation who is in need of an organ. Section 34 of the 1999 constitution of the Federal Republic of Nigeria affirms the right to the dignity of the human person. This section prohibits the unlawful infringement on the right of dignity of a person. One of the ways of protecting the dignity of the individual is to ensure that his body is not tampered with without his consent. In view of this constitutional provision, donation of an organ whether by a relation or a non-relation is a question of conscience and appeal to sentiment. This is exemplified by the United States of America in declaring February 14 2013 as the National Organ Donor Day with a view to raising the awareness for a way to spread love to someone who really needs it.

In *Curran v. Bosze* 566 2d 1319 (1990) the court refused to grant a petition to a plaintiff who had a set of twins for the defendant. The plaintiff had instituted a suit praying the
court to order that the twins be submitted for blood tests to determine their compatibility with their stepbrother, with a view to transplanting their bone marrow to the stepbrother who had leukaemia.

For the reason of consent, donations from cadaveric sources give immense legal challenges. There are two regimes for voluntary consent from cadaveric sources. These are ‘opt in’, that is, a person who gives explicit consent is a donor and ‘opt out’, that is, a person who has not refused is a donor.

There are three possible ways of providing evidence of an ‘opt in’ situation. Through this evidence, a person may expressly disclose his or her wish to donate a specific organ in the event of his or her death. These are;

a. Living Wills – A Living Will may direct that an individual’s organ be donated for a specific purpose. The enforcement of this will however be determined by the executors to the Will

b. Power of Attorney – In this situation, a natural or artificial person may be endowed with a power of attorney instructing the donation of the donor’s organs upon death.

c. Medical Directive – Here, the donor instructs the physician as to what to do with his body organs upon death.

The last two are assumably incorporated into section 55(a)(ii) and (iii) of the National Health Act, 2014. There is the new method of ‘opting in’ that is adopted in the United States, United Kingdom, Austria and South Africa among others. This is by the possession of an organ donor card.

In the organ donor card, the donor indicates preference in terms of organ. In all situations of this nature, four categories of persons are involved. These are the patient who eventually is the cadaver, the family, the medical practitioner and the recipient.

Cultural beliefs tend to play down the wishes of a person in ‘opt in’ cases. One of the reasons for this is the desire of an African to be wholly buried and not mutilated due to surgery for the excision of an organ. This may be dictated by the various ethnic nations that constitute the nation. For instance, among the Yorubas of the South West, it is an abominable thing to be buried without the complete body. Indeed, it is usually alleged that before a person who is a member of a cult is interned, his spirit will be invoked while his body will be checked by
his colleagues to be sure that no parts of his body are missing.

For the fact that the operating rules are customary, they are not formal or written. This is not to assume that they are issues for rule of the thumb. The average South Westerner is a product of the community. In some cases, there are communal activities for the betterment of the community. It is in light of this that consent for donation of an organ can be viewed. The situation will certainly be novel, in a local setting like Oyo in the northern part of the South West of Nigeria or Ekiti in the north eastern part, to seek and obtain consent from the relations of a deceased for the removal of an organ from their demised or living relation. The situation may be different in the metropolis like Lagos because of its urban nature. In the rural communities, removal of organ from either a living or a dead person will not gain consent as the use might have fetish connotations. The Edo people of the South West see the body as sacred and not to be dismembered or violated. They believe in reincarnation and that the body is only a vehicle for the soul or human spirit. For this reason they comfort relations of the deceased that the deceased is not dead but has only transcended this life as his/her soul has gone beyond human perception. This is captured in the following Edo expression: ’wa ghe vie ba nwen no wu’. This literally translated means ‘the transcended soul reincarnates fourteen times to atone for perceived sins before going into sublimation or eternity’. By this, relations are consoled with the fact that their dead relation will still return to them.

It is therefore believed that dismembered body may be missing in subsequent reincarnation. This is how the Edo people explain birth defects. These ancient traditional beliefs are gradually giving way to modern thinking that organ donation saves and prolongs the lives of the recipients and as such should be encouraged. There is really no scientific basis to link the violation of the body for the purpose of extracting an organ for the use of another person with the possibility of reincarnation of the person. This occurs as well in the north and the eastern parts. Among the Hausas/Fulanis and the Igbos respectively, there is more respect for the dead body than the living person. For this reason, it will be seen as a terrible act to violate the body of a dead person.

The northern part of Nigeria is inhabited predominantly by Muslims. The Islamic culture is that a dead person must be interned before the next sunset after his/her demise. In this case, it will be difficult to approach a freshly grieving family for consent to remove an organ from a dead relation. The position will not be different if such a demand is
made to a living person who probably never heard of transplant. The only way out of this situation is mass enlightenment focused on the gains of giving consent for the removal of an organ for use by a person who is in dire need of it as against considerations for a dead person who no longer needs it.

The Corneal Grafting Act, Cap C24 Laws of the Federation of Nigeria 2004, with specific mention of the eyes in section 3, provides that a person may have his eyes removed for therapeutic purposes after his death if he, either in writing at any time during his lifetime or orally, in the presence of two or more witnesses during his last illness, expressed a wish that his eyes be so used unless there is reason to believe that the wish was subsequently withdrawn. Section 1(1) and (2) of that law allows a person who is in lawful possession of the body of a deceased person to authorise the removal of the eyes from the body for therapeutic purposes unless that person has reason to believe that the deceased had an objection to his eyes being so dealt with after his death which was not withdrawn or that the surviving spouse or any surviving relation objects to the deceased’s eyes being so dealt with.

In section 3 of the Anatomy Act, Cap A16 Laws of the Federation of Nigeria 2004, it is provided as follows; ‘It shall be lawful for any executor or other person having lawful possession of the body of any deceased person and not being an undertaker or other person entrusted with the body for the purpose only of internment, to permit the body of such deceased person to undergo anatomical examination, unless to the knowledge of such executor or other person such deceased person shall have expressed his desire, either in writing at any time during his life or verbally in the presence of two or more witnesses during the illness whereof he died, that his body after death might not undergo such examination, or unless the surviving husband or wife or any known relative of the deceased person shall require the body to be interned without such examination’.

The issue of consent to donate does not arise in artificial organs. This is because the source is the government, corporate entity or charity organisation. Artificial organs are still at their evolutionary stages and are mainly available in false dentition, limbs, synthetic lenses and pace makers among others.

The shortage of human organs for the purpose of transplantation has pushed research to the use of animal organs in human beings. In this respect, organs from primates like baboons, chimpanzees and gorillas have been found to be expedient in replacement for
ailing human organs. Pigs have also been considered for this purpose because of the possibility of extinction for the primates. This is referred to as xenotransplantation. Consent for donation cannot be given by an animal but the recipient ought to be informed in order to save him from the psychological torture of the knowledge that he carries an animal organ in his body.

Regarding the use of animals for extraction of organs for use in human beings, there are no Nigeria laws. However, the Nigerian Criminal Code, Cap C38 Laws of the Federation of Nigeria 2004 makes provisions for cruelty against animals along with sanctions against culprits. It is greatly debatable if removing an organ from an animal for use in a human being will amount to cruelty as defined in the Criminal Code. What will not be in doubt is that, the life of a human being is worth more than that of an animal. In view of this, removing an organ in an animal for the purpose of transplantation into a human being may not fall into the category of acts referred to in section 450 of the Nigerian Criminal Code.

7.0 Organ Banking

The possibility of transplanting an organ from one body to another enhances health and improves the quality of life in the recipient of the organ. For this reason, there must be an improvement in the willingness to donate organs. This would help in acquiring more organs for use by persons who need them. The sources of these organs are from human beings (living and dead), animals, and in the case of artificial organs; government and non-governmental organisations. Quite different from the possibility of donating an organ for use by an ailing person, acquiring organs may also assist in breaking grounds in medical and clinical research.

This means that acquisition of organs is an important factor in medicine. In order to preserve the organs acquired, there is the imperative of an organ bank for the storage of organs that are acquired from donors.

An organ bank is a repository that is usually shared by multiple hospitals for long-term storage of certain organs that are meant for transplantation. The industry of organ banking, in its *modus operandi*, is not much different from money banking. The main point of diversion is the product that is banked. Whereas in a money bank, transactions are carried out on legal tenders, in organ banking, transactions are carried out on human (and sometimes animal and artificial) organs. They are institutions to whom organs may be donated and procured.
Organ banks deal with storing organs, distributing them for transplantation and research purposes. In view of the intricate and delicate nature of their products, they need to research into storage technologies. This has the possibility of enhancing the quality of the organs stored and the use of these organs. Banking makes it possible to have organs preserved and transported over considerable distances.

8.0 Commercialisation of Organs.
Organ transplantation remains one of the giant strides of medical practice. It has prolonged and improved the lives of many persons all over the world. The donation of organs for altruistic reasons by donors and their families is a practical example of being the ‘brother’s keeper’.

In view of the fact that successes have been recorded in transplantation operations, patients with ailing organs have opted for transplantation. The effect is that there is a high demand for organs and the resultant commercialisation of them.

The Istanbul Declaration 2008 defines Transplant Commercialism as ‘a policy or practice in which an organ is treated as a commodity, including by being bought or sold’. Article 4 of that Declaration states that the primary objective of transplant policies and programmes should be optimal short and long term medical care to promote the health of both donors and recipients. That article provides a rider as follows; financial considerations or material gain of any party must not override primary consideration for the health and well-being of donors and recipients.

Article 6 of the same Declaration states that organ trafficking and transplant tourism violate respect for human dignity and the principles of equity and justice and should be prohibited. For the fact that transplant commercialisation targets impoverished and otherwise vulnerable donors, it inexorably leads to inequity and injustice and should be prohibited. In seeking for this prohibition, Article 6(c) is clearly against practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners and political or economic refuges) to become living donors and it states that these practices are incompatible with the aim of transplant tourism and transplant (organ) commercialisation.

The Declaration of Istanbul was proclaimed at a summit meeting held in Istanbul of more than 150 representatives of scientific bodies from 78 countries around the world.
which included representatives of governments, social scientists and ethicists among others.

With respect to this Declaration, it is submitted that a Declaration falls under the generic term ‘Treaty’. The latter term covers a multitude of international agreements, instruments and contracts between states. That term also has under its umbrella terms like charter, protocol, pacts, covenants and conventions. They are all different contemporary synonyms for treaty which is a source of international law.

The binding nature of treaties lies in the heart of international law and is derived from the ancient Latin maxim, *pacta sunt servanda* which roughly translates as ‘promises must be kept’.

The provisions of a national law often challenge the binding nature of a declaration in international law. It is imperative that an international instrument be situate, interpreted and applied within the framework of the judicial system in force at the time of interpretation (Sokefun, 1999:163). Within the context of section 12 of the 1999 Constitution of the Federal Republic of Nigeria (as amended), no international document can be enforceable in Nigeria without the assent of the National Assembly. It is within this context that the efficacy and enforcement of the Declaration of Istanbul in Nigeria can be questioned.

Section 12 of the Constitution of the Federal Republic of Nigeria, 1999 succinctly provides as follows:

(i) No treaty between the Federation and any other country shall have the force of law except to the extent to which any such treaty has been enacted into law by the National Assembly.

The implication of this provision is clear. It means that for any international instrument to be enforceable in Nigeria, it must have been enacted into law by the National Assembly.

This section was interpreted by the Supreme Court of Nigeria in *Abacha v. Fawehinmi* (2000)6 NWLR (Pt. 660) 228. In that case the court decided *inter alia* as follows; (a) a treaty remains unenforceable until enacted into the law of the country by the National Assembly (b) where an international treaty entered into by Nigeria is enacted into law by the National Assembly, it becomes binding and courts must give effect to it like all other
laws falling within the judicial powers of the courts (c) a treaty is not superior to and
does not override the constitution.

The Nigerian Criminal Code makes provision specifically for possession of human skull.
It provides as follows;(1) Any person who receives or has in his possession a human
head or skull within six months of same having being separated from the body or
skeleton with the intension that such head or skull shall be possessed by himself, as a
trophy, juju or charm or transferred by him to another person as a trophy, juju or charm
is guilty of a felony and is liable to imprisonment for five years. This section does not
mention an organ of a human being therefore possession of organs does not fall into its
purview.

Section 53 of the National Health Act, 2014 expressly prohibits the sale or trade in
organ “....except for reasonable payment made in appropriate health establishment for
the procurement of tissues, blood or blood products.”
Until this section is subject to judicial dissection and interpretation, the meaning of the
italised words can never be known. Oliver Wendel Holmes, that respected American
stated it clearly that, jurist, law is what the judge says it is.

Trafficking is identified as source of procurement of commercialised organs. The
Nigerian Trafficking in Persons Law Enforcement and Administration Act 2003 prohibits
all forms of trafficking. This law was amended in 2005 to increase penalties for
traffickers. Traffickers have been known to use their victims for the purpose of organ
extraction for sale. With the operation of this law, it is likely that trafficking in human
beings will reduce.

Arguments against commercialisation of organs gravitate towards paternalism. They
give a reflection of the protection of persons. For instance the argument that organs
should not be commercialised has been attached to the fact that the integrity of the
human body should never be subject to trade and that it is unethical to exploit
vulnerable donors.

This argument both in its protection of the integrity of the human body and exploitation
of it is paternalistic. It has the goal of protecting the body of the person by the law. From
whatever side of the prism the viewer stands, the body of a human being ought to be
protected by law. Law and the state have the duty to provide the citizens with facilities for good health. The sale of organs is essentially rooted in the urge to survive and the shortage of organs is the basis for commercialisation. The law and the state are therefore in the middle of a potential challenge of balancing the interest of the vulnerable donor of a commercialised organ against that of the willing purchaser whose life depends on the organ. There is the likelihood of the failure of the paternalistic role of the state in this scheme of things. For instance, the purpose of allowing the sale of organs may not be for the improvement of the health status of the sellers or to award them long term economic benefit. It only provides short term economic benefit to the detriment of their health. These benefits are not conceivable in altruistic donations. To stem down the pecuniary expectation in organ sales, the state ought to make and enforce provisions for the welfare of the individual.

Commercialisation of organs could lead to inequity in terms of use of the organs. In the first place, organs would be allocated to the highest bidder and the ability to pay may overshadow the medical needs for the allocation of an organ. Ancillary to this is that the altruistic aspect of donation will be defeated once there are pecuniary advantages to be derived from the exercise.

One grotesque advantage of the commercialisation of organs is that it will make the organs to be available although for a fee. While it is admitted that allowing a free trade of organs will make them available, save lives and possibly boost the economy of some nations, such a practice would ultimately be against the right to dignity of human person as provided, for instance, in section 34 of the Constitution of the Federal Republic of Nigeria which provides: (i) Every individual is entitled to respect for the dignity of his person, and accordingly 1999

   (a) no person shall be subjected to torture or to inhuman or degrading treatment.

   Section 10 of the Constitution of the Republic of South Africa 1996 provides that ‘Everyone has inherent dignity and the right to have their dignity respected and protected and section 12(2) provides that ‘Everyone has the right to bodily and psychological integrity, which includes the right

   (b) to security in and control over their body and

   (c) not to be subjected to medical or scientific experiments without their informed consent’. With this provision, once there is consent, medical or scientific experiments (including removal of organs) can be carried out on a person without
an infringement on his constitutional right to freedom and security of the person.

9.0 Legal overview of organ transplantation:

9.1 Controversies Surrounding “Brain-Death”

There are moral and legal rights, obligations and protection endowed unto a person by law. These rights are extinguished at death when they are in personam. The advancements in sciences, particularly neurological science and technology have posed challenges at the traditional, and perhaps layman’s view of death being the end of the life of a person, that is, a stage in which a person has lost the ability of rational thinking and is permanently unconscious. That is the stage at which all rights on personhood are extinguished.

Warren (511), in one of her philosophical writings identified five traits of personhood as follows:

a. Consciousness – the capacity to feel pains
b. Reasoning – the developed capacity to solve new and relatively complex problems
c. Self-motivated activity - activity which is relatively independent of either genetic or direct external control.
d. Capacity to communicate, by whatever means, messages of an indefinite variety of types
e. The presence of self - concepts and self-awareness

Warren assumes that their existences make a person although they all might not exist at the same time. It appears agreeable that these traits must exist in all persons but they may not exist simultaneously. For instance, a person might not be able to communicate but still possess the ability to rationalise on complex issues. In the absence of the latter trait the person does not cease to be a person. A person may not have the capacity to reason but may be able to feel pains and still exercise some emotion.

This second example occurs in cases of mentally retarded persons. They remain persons, with rights and protection by the law, in spite of their inability to reason.

If we take Warren’s postulations on personhood as the pivot of a discussion on this matter then it would be glaring enough that all these traits, as itemised by the author,
are possessed by some non-humans. In this respect, we may use the example of lower animals like gorillas or the impala or even Pisceans like the porpoise or cichlid. They all possess these traits yet they are not persons. If we use the criteria set down by Warren, we may include these non-humans as persons and exclude some vulnerable human categories, like the mentally retarded and persons of unsound mind from our definition of persons.

It is safer to adopt the view of Epicurus (Saunders: 40) that, ‘…..when we are, death is not come, and, when death is come, we are not’.

No doubt, the issue of determination of death has generated much controversy although this has simmered down in the last decade. In contributing to this controversy, the Institute of Biomedical Ethics, Zurich as recently as 2012, admitted that the need to define death has become a distinctive trait of contemporary medicine. They noted that in the past, there was little controversy that a patient was dead when the heart or lungs had irreversibly ceased to function. In this connection, continuity of life is linked with the functioning of the heart and respiratory activities. It is noteworthy that this notion imperatively changed after the technological advancement into life sustaining methods like cardiopulmonary resuscitation and other mechanical provisions for ventilation which could sustain persons with severe brain damage. With all these, it can be contended, at this point, that a person who is mechanically sustained but with no brain activity could be considered dead or in the process of dying. This therefore leads to the issue of brain-death as the criterion for determining death.

Brain-death is the contemporary medical expression for death, the demise of a person. In whatever form that this phenomenon may be expressed, death is the transition from being a living, organism to being a lifeless bundle of inactive organs.

With relation to organ donation, the issue of determination of death is important for two reasons. The first concerns cases of sustenance of the patient by technological means. In this context, the issue is about the stage at which such technological means may be withdrawn by the medical practitioner when he takes the decision that the patient has died and no human activity exists in the patient’s system. Ancillary to this is the stage at which the medical practitioner may proceed to remove organs from the body for the
The purpose of transplantation into another person. Otherwise such practitioner may be guilty of an offence and may also have some civil liabilities against him.

These two issues, among others were considered in 1968 by an Ad Hoc Committee at the Harvard Medical School. That Committee sought to settle the first issue above by defining ‘irreversible coma’ as a situation where ‘no discernible central nervous system’ exists. That committee came up with what was later referred to as ‘Harvard Criteria’ which defined brain-death in terms of loss of function of the whole brain and gave a clinical picture of lack of responsiveness and absence of brainstem reflexes and apnoea. This definition has been adopted in most jurisdictions. An authoritative stamp was given to these criteria in the United States of America by the promulgation of the Uniform Determination of Death Act 1981. This Act gave definition to death determined by neurological and cardiovascular criteria.

Many jurisdictions have adopted the concept of death from the standpoint of the Uniform Determination of Death Act of the United States of America. The Act relies on the brain formulation while stating that ‘an individual who has sustained irreversible cessation of all functions of the entire brain, including the brainstem is dead. This has formed the mainstay of determination of death based on neurological criteria in most jurisdictions.

In most countries, it is accepted that the condition of brain-death equates medical, legal and religious terms with the demise of the patient. There is not much literature on this issue in Nigeria except some tangential discussion by Bakari et al (2012:55) who suggested that for a patient to be dead, such a patient must have suffered major brain damage, be deeply unconscious and require artificial ventilation. The authors warn that particular care must be taken to ensure that muscle relaxants and drugs with depressant have not contributed to that clinical state.

Muscle relaxants and barbiturates have among their qualities, the ability to reduce pulse and in situations of overdose they may cause unconsciousness. For this reason, it is necessary for the medical practitioner to be sure that such drugs have not contributed to the present state of the patient.
This argument may linger on for a long period than imaginable. For instance, in Nigeria, no statute yet defines that term. The issue to address is the point at which point death can be declared.

No matter the quantum of literary contributions in this respect, it is imperative that a legislative definition of death be provided. This will, at least, serve as a guide to both the practitioner, the patient and his/her relations and the Barrister if and when his services are required.

**9.2 Donations after Circulatory Death (DCD)**

Donation of organ occurs under two circumstances. It could occur where the donor, whether related to the recipient or not, voluntarily donates his organ for altruistic reasons. In this case, the consent of a competent adult is required for the surgical operation of the removal of the organ from the body.

Donations from living donors do not create controversies like donations after circulatory death (dcd).

While alive, an individual may choose to donate his organ after his death. This is allowed under section 55 of the National Health Act. This section gives statutory flavour to the donation of a body by a person when he is still alive which would be effective *post mortem*. This provision is supported by section 56 of the statute which provides a near exhaustive list of purposes of donation of body, tissue, blood or blood products of deceased persons. That section provides: ‘A donation in terms of section 62 may only be made for –

a. The purposes of the training of students in health sciences:

b. The purposes of health research

c. The purpose of the advancement of health sciences

d. Therapeutic purposes, including the use of tissue in any living person:

e. The production of a therapeutic, diagnostic or prophylactic substance.

From this list, it is clear that the statutory purposes for the donation of a body or any of the organs of a human being are either for research or therapeutic purposes.

After death, decisions on donation of organs are taken by the relations of the dead person. They may choose to offer specific organs for donation to waiting recipients. On the other hand, the dead person (now a cadaver) may have expressly disclosed his/her wish to donate a specific organ upon death.
There are two ways for voluntary consent from cadaveric sources. These are the ‘opt in’ and ‘opt out’ regimes. In the ‘opt in’ regime, a person who gives consent is a donor. In this method, by the concept of presumed consent, every member of the society is presumed to have agreed or consented to donate his or her organ upon death unless he or she specifically takes action to be excluded from the process. In the ‘opt out’ system, a person who has not refused is assumed to have wished to be a donor. In both situations, there are matters arising.

In the ‘opt in’ situation, there are three clear means of discerning consent.
These are:
   a. through living wills
   b. power of attorney and
   c. medical directive.

The current regime of organ donation in Nigeria is the ‘opt in’ system. By this, those who wish to donate their organs make their intentions known to friends and family members. Usually, live donations are due to altruistic reasons.

The statutes that bear relevance to the National Health Act on donation of an organ after circulatory death and the examination of the cadaver are the Corneal Grafting Act and the Anatomy Act respectively.

As the name of the statute implies, the Corneal Grafting Act is specifically an enactment on eyes. Section 1(1) and (2) of the Act permit an individual who is in lawful possession of the body of a deceased to authorise the removal of the eyes from the body for therapeutic purposes unless that person has reason to believe that the deceased had an objection to his eyes being so dealt with after his death which was not withdrawn or that the surviving spouse or any relation objects to the deceased’s eyes being so dealt with.

The Anatomy Act is specifically on examination of cadavers. It does not have any provision on donation or removal of an organ. It deals with anatomical examination. For this reason, except for the purpose of discussion, the Act is not helpful in terms of providing authority for the donation of an organ.

From the above, it can be safely concluded that in Nigeria, the ‘opt in’ method is in operation in organ donation.
## 9.3 Cultural Influences on Organ Donation

### 9.3.1 Religious Factors

Religious factors have their influence on organ donation. In all religions and culture, the dead body is held as sacred and respected.

In India, for instance, cremation is compulsory for Hindus for which reason donation of an organ talk less of the body may never be considered by members of that tribe. With the Muslims, dead bodies are sacred and buried as soon as possible after death. This happens to be a tenet of Islam which is the culture of all Muslims. In Islamic jurisdictions, laws are fashioned along the lines of the Quran and any new ideas or protocols may have to go through the will of Islamic teachings and norms in order to be permissible. In this situation the donation of an organ or a body as whole will be influenced by the pronouncements in the Quran and the Hadith which form the basis for the Shari’ah.

In the Islamic culture and religion, there are two schools of thought on donation of organs and transplantation. Both schools cite portions of the Quran and Hadith in support of their claims.

The first school admit of the legality of donation and transplant. The mainstay of this school of thought is that Allah intends to ease and He does not make things difficult (Holy Quran, Chapter 2 verse 185). They also rely on the fact that Allah forbids the consumption of dead meat blood and pork, but if one of necessity, without wilful disobedience consumes these, he/she shall be guiltless (Holy Quran, Chapter 2 verse 173).

These Quranic verse is all about necessity which could be the raison d’etre for the donation and transplantation of an organ.

On the other side of the divide are those who oppose donation of organs and transplantation. They support their stand by citing the same Qur’an. For instance, they quote the Qur’an as follows: ‘I will mislead them, and I will create in them false desires; I will order them to slit the ears of cattle and to deface the nature created by Allah (Holy Quran, Chapter 2 verse 119)’. They also cite the Hadith which positively declares: ‘do not maim’. Division in opinions is not unexpected in a situation like this where no specific position.
It is in indubitable that the donation of an organ for the purpose of transplantation into another person has the possibility of allowing the recipient to live a better life after the operation. It is in view of this that the arguments of the second school of thought would carry no weight. In spite of our submission, the two views on donation and transplantation of organs in Islam show the influence of culture and religion in organ donations. Faraj et al (2010:714) have offered a panacea to this situation. They suggest that laws governing areas of potential social or ethical controversy have to agree with Islamic teaching. In any case, the Islamic Code of Medical Ethics of 1981 upholds as follows; ‘If the living are able to donate, then the dead are even more so; no harm will afflict the cadaver if the heart, kidneys, eyes or arteries are taken to be put to good use in a living person’.

In Christianity, the dead body carries great values. It must not be disrespected under any circumstances. As a matter of fact, any dead body is expected to be treated and given a befitting internment.

The Holy Bible is replete with many verses where patriarchs gave instructions as to what to do with their bodies after their demise. These injunctions were carried out without any alteration. A clear instance was that of Jacob (also known as Israel) who gave a definite instruction to his offspring to ensure that he was not interned in Egypt, for which reason, he was taken to Canaan for internment (Holy Bible: Genesis Chapter 50 verse 13). The bones of Joseph were carried along with the Israelites on departure from Egypt and interned in Israel (Holy Bible, Genesis Chapter 5 verse 25).

In the Bible, what may support the donation of an organ for the purpose of transplantation is the injunction which proclaims: ‘Love thy neighbour as thyself’ (Holy Bible, Mathew Chapter 22 verse 39). This short verse is laden with meanings. Aside the ordinary interpretation that one should make the welfare of others his/her business, by extension, it could also include the donation of an organ to a person who is in need of it. For instance, it could include the donation of one kidney to a person whose two kidneys have ceased to function. It could also include the donation of an organ of a dead person for the use of a living person who is in need of it. By biblical injunction (Holy Bible, Exodus Chapter 20 verse 13), it would not include the removal of life support technological devices which would hasten death in order to procure an organ or neglect of a patient to die in order to remove his/her organ.

From a cursory review of the Bible and the Christian standpoint, there appears to be no negative viewpoint on donation of organs. The simple injunction to ‘Love thy neighbour
as thyself’ is enough to influence donation of organs where it would produce no negative effect on the donor. The Pope is regarded as the inheritor of the authority of Peter the Apostle. Pope John Paul II affirmed that organ donation is an act of love when it is done in an ethical manner. See Evangelium Vitae No. 86. In an address at the first International Congress of the Society for Organ sharing on 20 June, 1990 Pope John Paul considered donation and transplantation as gestures which allow others to continue to live. This position, like in the case of Islam, is also debatable because of the absence of a specific position in the Bible.

From the traditional viewpoint in Nigeria, organ donation is discouraged due to the belief in reincarnation for which reason a person is expected to be buried as a whole without any dismemberment. One grotesque aspect of tradition in respect of sickness is the belief that sicknesses which result in death are spiritually propelled. For this reason alone, the only option on the body is internment and the issue of donation does not arise.

In a field survey in the course of this research, 300 persons divided equally between the sexes, were randomly chosen and interviewed at Balogun Market, Lagos, Nigeria on whether they would like their relations to donate their bodies after their death. 18% (54) claimed that they were aware of removal of organs for transplantation. 83% (250) objected vehemently, 25% (75) of them introduced spiritual factors and said that if any relations ever donate his body for removal of an organ, they will not rest in peace and if they do not rest in peace, the living members of the family who gave consent to the donation will hop from one catastrophe to the other. 12.6% (38) persons consented with the condition that the parts removed should be used for therapeutic purposes and the rest of their bodies should be interned with dignity. 3.3% (10) of the samples said that they did not care what was done to their bodies after death; 2.3% (7) of these were sure that leaving their bodies unattended to would cause discomfort to the neighbourhood and so it was in the interest of their relations to intern their bodies anyhow. 0.6% (2) did not respond because they were nonchalant. A graphic impression is provided in Table 3.

The choice of Balogun Market, Lagos, is due to the fact that it is the biggest and oldest market patronised by both the elites and non-elites in Lagos. It is also the only market within the heart of Lagos that has an antiquated and respected mosque as well as a church with same values. To complement this, a stirpe of one of the ancestral deities of
Lagos, referred to as the Eyo Masquerade, takes its origin from the environs of this market. It is therefore expected that the market would consist of a mix of culture, religion and different classes of educational background that will assist in providing the information required for this research.

**TABLE 3**

**Field Survey at Balogun Market, Lagos, Nigeria**

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</tbody>
</table>

**TABLE 4**

**Instrument of Survey on Field Survey at Balogun Market, Lagos, Nigeria.**

1. First name:__________________________________________
2. Religion: ____________________________________________
3. Do you know about removal of organs and transplantation of organs? __________
4. Would you want your body organ to be removed for transplantation after your demise

<table>
<thead>
<tr>
<th>S/N</th>
<th>Yes</th>
<th>No</th>
<th>With Condition</th>
<th>Do not care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
If with condition, what conditions?__________________________

With an 18% of the samples claiming to be aware of removal of organs and transplantation, it is clear that these phenomena still need drastic public enlightenment in order to be able to decipher whether or not it will be generally acceptable to the people. 25% introduced the non-scientific consideration of culture and religion into the issue of removal of their organs. This also gives the impression of the influence of religion and culture and that there needs to occur a complete change in paradigm if the concept of removal of organs is to be acceptable to the generality of the public. 12.6% accepted that their organs may be removed provided it was for therapeutic purposes and their bodies interned with dignity thereafter.

All the samples of our interview expressed the fact that their bodies belonged to them and that their relations will take the property in them after their demise and that the state cannot claim property in their bodies to the exclusion of their relations.

9.3.2.1 Legal Overview of Ethical Issues in Organ Donations and Use

Ethical issues on donation of organs carry with them legal consequences. They vary but in terms of occurrence they exist in all jurisdictions. This section presents a legal overview of these ethical issues.

The first of these issues is the right on the dead body. Admittedly, the cadaver is lifeless, irreversibly unconscious and cannot claim rights.

Being in this state, the first issue to address is whether it is a property and if it is, whose property is it?

In jurisdictions Like Norway and Denmark, particularly where the ‘opt out’ method obtains, the argument tilts towards state ownership of the body.

Viewed from any perspective, this stand cannot have the support of all jurisdictions. For instance, the lifeless body has relations who must have interacted with him when he was alive. These relations, by any known criterion, should own the body and be endowed with the right to dispose of it decently. This conclusion is supported by section 58(b) of the National Health Act of Nigeria which gives a clear view of the persons who may give consent to the donation of an organ of a dead person. Section 1(i) of the Corneal Grafting Act of Nigeria and Section 3 of the Anatomy Act also state those who may consent to donation of the eye and consent to anatomical examination.
respectively. None of these legislations gives the right of ownership of the body to the state.

One argument in favour of state possession of the body is the usefulness of the body for research and therapeutic purposes. With this, the state may take charge of possession of the body and use it for research.

In the report of a research carried out by Bari et al (2012:1134), the authors, through an empirical survey found out that there was no alternative to cadavers for anatomical dissection.

Emson (2003:127) believes that the human cadaver should be regarded as a resource for those who may benefit from the donation of the organs and the body after death. The basis of his argument is that after death the body inevitably decays after being disposed. Emson’s utilitarian argument may hold in ‘opt out’ jurisdictions. In jurisdictions where the ‘opt in’ method is in use, it will be difficult to convince relations to deliver the bodies of their kin to be used for research purposes except such an intention had been declared by the dead person while he was alive. The African cultural view of dead bodies is that it should be treated with respect. In the absence of a statutory backing for such a proposal, it may not be acceptable in any African jurisdiction, particularly Nigeria.

This raises issues in property rights. Some authors have claimed that property does not stand against the state but is created by the state. Morrison (2005:402), for instance considers some ways by which an individual may be entitled to hold something as his/her property as by acquisition and transfer. In terms of acquisition, he refers to the property as having not been that of another person and as for transfer, it means transfer by valid means. These he said includes gift, sale and inheritance.

If we use Morrison’s postulations as the basis of our consideration of the property right in a dead body then neither of the two ways suggested would ground the ownership of a cadaver by the relations and nay the state. By stroke of culture however, relations tend to have a sentimental reason for giving their dead a befitting burial which may not be given by the state except in cases of state functionaries. For this reason, property rights in the cadaver rest in the relations.

Property rights in the Constitution of Federal Republic of Nigeria 1999 are discussed in terms of ‘movable’ and ‘immovable’ property. Section 43 of that constitution states that ‘…. every citizen of Nigeria shall have the right to acquire and own immovable property anywhere in Nigeria’. As a follow up to this section, section 44 states that ‘no moveable
property or any interest in an immovable property shall be taken possession of compulsorily….’

The right in a cadaver has never been challenged in court by the state. For this reason, it remains a moot point if a cadaver will be accommodated within the meaning of ‘moveable property’ within the context of section 44 of the Constitution of the Federation Republic of Nigeria 1999.

The right of property in a cadaver in Nigeria resides in the relations of the dead person who have strict duties to the dead. Any practice against this may be morally and culturally unacceptable.

9.3.2.2 The other legal issue is the point at which death may be determined whereupon an organ may be removed for the purpose of donation for transplantation. This point will be better driven home by the chronicle of the first heart surgery. Engel, the Director of U. S. Coalition for Life gave an insight into the first heart transplantation by Barnard.

Engel reported that a certain Denise Darvall had been seriously injured in an accident which claimed her mother’s life. Denise’s father gave his permission to have his daughter’s heart excised and transplanted to a certain Mr. Washkansky who took credit for being the first human heart transplant patient in the world. This operation lasted 9 hours with 30 medical personnel.

Engel noted that at the time of the excision of Denise’s heart although her brain was damaged, her heart was healthy and still beating. There were indications that she was still alive by any standard. Marius, Barnard’s brother who assisted in the operation urged his brother after opening Denise’s chest to inject doses of potassium to paralyse Denise’s heart in order to render her technically dead.

From Engel’s account, a convenient deduction is that Denise was alive at the point of the removal of her heart.

From the account above, the ethical issue that can be extrapolated is that Denise’s life was taken by Barnard and she died after her heart was removed. In other words, Denise was murdered by Barnard in order to procure her heart for transplantation into Washkansky.
This single case, being one among others, raises the question as to the definition of death and the legal overview of ethical issues that arose from that definition. The generally accepted definition of death is the period when the patient is brain-dead and there is an irreversibility of brain function loss.

Removal of the organ at the time when the heart is still breathing and healthy is murder which by all world known standards is a crime. Section 33 of the Constitution of the Federal Republic of Nigeria 1999 guarantees the right to life and states that no one shall be deprived intentionally of his life save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty. By this, every person, including the patient has a right to life with an imposed duty on the medical doctor to ensure that as much as is professionally possible, death does not occur in the course of the treatment otherwise the medical doctor will be charged with murder.

9.3.2.3 Section 306 of the Criminal Code is unambiguous in this respect. It provides that ‘It is unlawful to kill any person unless such a killing is authorised or justified or excused by law’.

Section 316 of the Criminal Code provides inter alia that ‘Except as hereinafter set forth, a person who unlawfully kills another under any of the following circumstances, that is to say – (5) if death is caused by administering any stupefying or overpowering things ……is guilty of murder’.

It is submitted that when an organ is removed from the body of a patient who is ‘brain-dead’ but whose heart is still breathing, such an operation amounts to murder.

Section 38 of the Constitution of the Federal Republic of Nigeria 1999 does not make explicit provision on ‘medical and scientific experiments’. That section provides that ‘Every person shall be entitled to freedom of thought, conscience and religion, including freedom to change his religion or belief, and freedom (either alone or in community with others, and in public or in private) to manifest and propagate his religion or belief in worship, teaching practice and observance.

In interpreting this section, the Supreme Court of Nigeria in the case of Medical and Dental Practitioners Disciplinary Tribunal (M.D.P.D.T) v. Okonkwo [2001] 7 NWLR (Pt. 44) 542 F-G affirmed the patient’s constitutional right to object to medical treatment, or particularly, to blood transfusion on religious grounds. In that case, the respondent was
found guilty on two counts of negligence and acting contrary to his oath as a medical practitioner. He had treated a patient who refused blood transfusion consequent upon which she died. His appeal to the court of appeal was allowed while the conviction was quashed. An appeal to the Supreme Court was unanimously dismissed. Part of the judgment of Justice Uwaifo in that matter captures the purport and intendment of section 38 of the Constitution of the Federal Republic of Nigeria 1999. His Lordship had the following to say: ‘I am completely satisfied that under normal circumstances, no medical doctor can forcibly proceed to apply treatment to a patient full of age and sane faculty without the patient’s consent, particularly if that treatment is of a radical nature such as surgery or blood transfusion. So, the doctor must ensure that there is a valid consent and that he does nothing that will amount to trespass to the patient. Secondly, he must exercise a duty of care to advise and inform the patient of the risks involved in the contemplated treatment and the consequences of his refusal to give consent’.

The summation of both sections 38 of the Constitution of the Federal Republic of Nigeria 1999 is that every person is entitled to personal autonomy in respect of donation of organs which can only be derogated from by consent.

9.3.2.4. Another legal issue that arises from organ donations is in terms of human dignity. Whether in cases of live donations or cadaverous donations, the body of a person is entitled to be treated with dignity. Accordingly any inhuman or degrading treatment would amount to an infringement of the right of a person to dignity of his/her human person. This right imposes on the medical doctor the duty to respect the worth and person of the donor. In this wise, the body must not be brutalised or dehumanised in the course of donation.

In interpreting section 34 of the Constitution of the Federal Republic of Nigeria 1999, the Supreme Court of Nigeria, in *Uzoukwu v Ezeonu II* (1991) 6 NWLR (Pt 200) 708 at 764-765 defined the phrase ‘inhuman treatment’ in the following words: ‘any barbarous or cruel act or acting without feeling for the suffering of others’.

This aspect of the decision in *Uzoukwu v Ezeonu II* relates to the medical doctor’s duty of beneficence and non-maleficence. The medical doctor in the cause of procuring a donation from a live donor must act in the interest of the donor and the recipient as well. For instance, the medical doctor must consider the state of health of the donor and produce the judgement that is the interest of the donor regarding his/her state of health.
As for the recipient, he must ensure blood compatibility with the donor. Failure to do this may amount to professional negligence which could be fatal to the life of the recipient. In cadaverous donations, the medical practitioner must ensure that the death of the deceased person did not occur because of the failure of the organ being donated. In all, aside the ethical aspect of beneficence and non-maleficence, the medical practitioner must feel for the suffering of the donor and the recipient and must also share in the grief of the relations of the dead person from whose body the organ is being removed.

9.3.2.5 There is also the ethical issue of privacy in organ donation. The reason for this is not far-fetched. In the case of the recipient, there is the need to maintain privacy while experiencing crisis. As for the live donor, such a person may not wish to experience publicity in the donation. The case of the cadaveric donation has cultural factors attached to it. In this respect, it is noteworthy that in the Nigerian culture, the dead body is held sacrosanct and inviolable. Relations would therefore be looked at with disdain by other members of the local community if it is published that their relation was interned without some organs of the body.

There are various factors that can be identified with the support of respecting the rights of privacy of the donor and recipient. The first is cultural. It relates to the view of the community with respect to the donation and the receipt of the organ. This ethical aspect has attached to it some legal implications which turn on the right to privacy of all parties in the donation and use of the organ. The concern of the medical practitioner primarily should be to protect the patient from violation by the public, particularly the patient who may not be physically and emotionally ready for the publicity of the surgery. This aspect has to be considered against the responsibility of the medical practitioner to publish the result of his studies in order to enhance the possibility of future success in that endeavour. The patient is at liberty to release medical records, particularly information on donation and transplantation and the publisher may, with the consent of all parties, use the reports and records for the benefit of the public such consent having been freely given by the parties.

The right to privacy is guaranteed under section 37 of the Constitution of the Federal Republic of Nigeria 1999. That section provides that: ‘The privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed and protected’. This right includes the right of a competent and
matured person to refuse treatment that may prolong his or her life even when such reason is considered naïve by others.

By virtue of this provision, it can be safely inferred that the right to privacy of the recipient and the family of the dead donor is constitutionally protected and such right may not be violated except with their express consent.

Public policy and cultural factors do not appear to be of assistance in this respect. The ‘opt in’ method which is in use transcends the system and discourages donations.

9.4 Ethical breaches and remedies:

9.4.1 Disciplinary Procedures in Breach of Medical Ethics

In carrying out their professional duties, members of the medical profession are governed by standards which emerge from the ethics of the profession. These ethics are contained in codes and are meant for the maintenance of standards through the exercise of discipline against members who err by doing things that fall short of the ethical standards as stated in the codes.

One overt result of the existence of discipline is the effect of this issue on the public. The existence and enforcement of discipline within the medical profession provides confidence in the public who, in all cases, are the patients of the medical practitioners. This aspect has taken a more amplified dimension through the importance given to consumer rights, provider responsibility and the duty of care expected, not only from the medical profession but also from other professions as well. In view of this, accountability, in all forms, has become one of the great watchwords of product delivery, particularly healthcare delivery.

From the emergence of the Hippocratic Oath, there had been consciousness in the members of the medical profession of their responsibilities to their patients. This is borne out of the ancient Latin maxim ‘primum non nocere’. Translated literally, it means, ‘above all, do no harm’.

In contemporary times, this is referred to as ‘non-maleficence’. This is even more important in view of technological advancements in medical practice. One of such advancements is the life sustenance device (lsd) which, all other things being equal, could sustain a person’s life while other efforts are being made to do surgery, administer
medications and in other situations, remove organs which may be useful to other persons in less critical situations.

In medical practice, the intent to minimise harm is the *raison d’être* of non-maleficence while the intent to maximise benefits is the underlying factor for beneficence. These two values are core ethical principles in medical practice. They form the basis of the duty of the medical practitioner in rendering services according to clinical judgment. It is not impossible for the patient to misguide the medical practitioner by providing misinformation by way of exaggerated explanation of the patient’s medical situation. The situation could also occur by hiding information from the medical practitioner. In both cases, among others, there exists a strict ethical rule for the medical practitioner to be guided by beneficent and non-maleficent values in medical practice. The possible effect of misinformation could be harmful to the patient particularly when the information provided does not give reason for diagnostics or referral. At all events, even when patients have complaints against medical practitioners on matters like this, there are outlined procedures for the enforcement of relevant ethics and disciplinary measures where appropriate.

The issue of discipline emerges out of the rights of the patient, abuses and professional lapses. For instance, in transplantation matters, the first and indeed the most important issue is the time that death could be said to have occurred in a human being. This is important because there is yet no statutory definition of death. The controversy is ever so potent about the period and meaning of brain death because save for live organ donations, an organ cannot be removed from a person except the person is pronounced dead and had given consent while alive or consent was given by his relations after death.

In a bid to avoid this lacuna in the law, the 'Maastricht categories' of non-heart beating organ donors (NHBDs) for donation after death is suggested. It outlines four categories as follows:

i. Dead on arrival
ii. Unsuccessful attempts at resuscitation
iii. Controlled withdrawal of life support without attempts at resuscitation
iv. Cardiac arrest after brain death.
These categories do not appear to have international acceptance as they are not stated in any legal document or code of ethics of any jurisdiction. The position regarding their international acceptability remains nebulous. It is therefore difficult to adopt them as sacrosanct on any discussion on donation after death. If anything at all, they may serve as guide in producing an international set of criteria for this matter in the future.

In the medical profession, what would be seen as a breach could come in the form of breach of duty and ethics, criminal acts or ‘infamous conduct’. Persons who do any of the acts may be disciplined in one form or the other by the disciplinary body of the Medical Council.

Breaches are easy to discern and they carry both statutory and ethical condemnation by way of sanctions. Criminal acts are also easy to discern. They are acts that run against the criminal code in the jurisdiction. Acts that may be considered as ‘infamous conduct’ do not appear in that shape. They are amorphous. As a matter of fact, Berlant (1975:161), in an attempt to provide a general guideline for ‘infamous conduct’ ended up providing exceptions. He pointed out that that ‘infamous conduct’ did not include ‘mistakes or incompetence short of gross malpractices and incompetence’. This definition is not helpful in ascribing a definition for acts that constitute ‘infamous conduct’.

The issue of disciplinary measures against medical practitioners became a subject of discussion after 1900.

Using British examples, Pyke-Lees (1985:25), the former Registrar of the British General Medical Council, in an old publication, noted that medical treatment became more efficacious as a result of the rise of scientific medicine in the late nineteenth and early twentieth centuries.

For this reason, public expectations of the professions became more exacting. He noted further that the rise of microbiology and the concomitant rise in the knowledge of aetiology and control of diseases coupled with the increasing success of surgical techniques with the discovery of antibiotics have helped to create the anticipation of long and healthy life to human beings.

In concluding his views on this matter, Pyke-Lees noted that for the reasons given above, there emerged a new climate of thinking attitudes towards the medical profession. In his view, while on the one hand doctors were seen to be heroic miracle workers, on the other hand, their practice failures were regarded with the vengeful
savagery of those whose high expectations had been betrayed. The effect of all these was a new emphasis on discipline within the medical profession.

Needless to say, it is imperative to have guides and some minimum benchmark in the practice of medicine and the swiftly emerging issue of transplantation of organs which usually have effects on the life of the individual. This is even more important in cases of transplantation of organs which may assist in prolonging the life of the patient particularly in cases of end stage medical situations.

Medical practice in Nigeria is guided by the Medical and Dental Council of Nigeria. As the name implies, this Council also has charge over dental practice. It is a creation of the Medical and Dental Practitioners Act. Cap M8 Laws of the Federation of Nigeria 2004. The Act establishes the Medical and Dental Council of Nigeria for the registration of medical practitioners and dental surgeons and provides for Disciplinary Tribunal for the discipline of members. One of the statutory functions of the Council as contained in section 1(2)(c) of the Act is to ‘review and prepare from time to time a statement as to the code of conduct which the council considers desirable for the practice of the professions (medicine and dentistry) in Nigeria’.

This document serves as an information source for medical practice, teaching and in fact legal advice to patients and medical practitioners. The underpinning of the document is the expectations of the public, government and the medical profession from the medical practitioner. It also provides the disciplinary procedures in cases of breach of medical ethics.

Rule 6 of the Code of Medical Practice in Nigeria provides the legal basis for medical and dental practice. That code states that: ‘Any person who practices medicine or dentistry anywhere in Nigeria without being appropriately registered with the council contravenes the law and so does his/her employer’. Accordingly, that code provides categories under which a practitioner may be registered as follows;

i. Provisional registration
ii. Full registration
iii. Limited or temporary registration
iv. Registration as a specialist

The general principles of the ethics of the medical profession in Nigeria are seventeen in number. They are contained in Article 9 of the Code. These principles revolve around
six values which are contained in Article 9 (a) (c) (d) (f) (m) and (n). For ease of reference, they shall be quoted *verbatim* as follows;

(a) The principal objectives of the medical practitioner shall be the promotion of the health of the patient. In doing so, the practitioner shall also be concerned with the common good while at the same time according full aspect to the *human dignity* (emphasis mine) of the individual.

(c) Practitioners must strive at all times not only to uphold the honour and to maintain the dignity of the profession but also to improve it. Practitioners shall deal honestly with colleagues and patients at all times.

(d) Practitioners shall always strive to observe the laws of the land (emphasis mine)

(f) All communications between the patient and the practitioner made in the course of treatment shall be treated in strict confidence by the practitioner and shall not be divulged unless compelled by law or overriding common good without the consent of the patient.

(m) Practitioners must not certify what they have not personally verified; they must desist from compulsory treatment of a patient in the absence of illness and must not collaborate with agencies to label somebody ill in the absence of any illness, but must always obtain consent of the patient or the competent relatives or seek another professional opinion, before embarking on any special treatment procedures with determinable risks.

(n) In performing biomedical research involving human aspects, practitioners must conform to generally accepted scientific and moral principles and must obtain consent from their subjects and take responsibility to ensure the protection of their integrity and confidence.

The six values distilled from Article 9 of the Code of Medical Ethics in Nigeria revolve around the following;

(a) human dignity

(b) observance of the laws of the land

(c) right of privacy

(d) consent in treatment procedures

(e) consent in biomedical research

As for human dignity, the Code of Medical Ethics in Nigeria generally emphasises that all patients must be handled with dignity at all times by the medical practitioner. This is
an aspect that is co-joined with the observance of laws within the jurisdiction, the highest of which is the Constitution of the Federal Republic of Nigeria 1999.

As for consent to treatment, again, the Constitution forms the bedrock of any argument on this matter. The patient is constitutionally endowed with the right to elect to consent to be treated. It is an aspect of the private life of the citizen which is protected by section 37 of that Constitution. Section 37 of the Constitution provides; “The privacy of citizens, their homes, correspondence, telephone conversations and telegraphic communications is hereby guaranteed and protected”. As a fact, for religious reasons, a patient may refuse to consent to treatment even when such treatment is the only way by which his/her life would be saved. Section 38(1) of the Constitution of the Federal Republic of Nigeria provides as follows: ‘Every person shall be entitled to freedom of thought, conscience and religion, including freedom to change his religion or belief, and freedom (either alone or in community with others, and in public or private) to manifest and propagate his religion or belief in worship, teaching, practice and observance’. This was the crux of the matter in the case of *MDPDT v. Okonkwo* [2001] FWLR (Pt 44) 542 where the patient refused blood transfusion on the basis of her membership of the Jehovah’s Witness sect, a Christian religious denomination that reject blood transfusion.

This issue of consent percolates into medical surgery and research as well. In Nigeria, Form MDCN/ COMEIN/ R19 forms part of Article 19 of the Code of Medical Ethics in Nigeria. It is the consent form which must be completed and signed by a patient or guardian before a surgical operation can be performed. The Form is in Table 5 of this work.

**TABLE 5**
CONSENT FOR SURGERY/PROCEDURES

I..................................................of............................................

(full names, surname first)            (full address not P.O Box)

hereby, after detailed explanation of the advantages and disadvantages to me by

Dr ...........................................................willingly consent to the

(full names, surname first)

procedure of ........................................on

[Specify]

myself / child / spouse / mother / father / others ....................

(Indicate as applicable

I affirm that i clearly understand the language of representation.
The option to think over the procedure for a period before assenting was also presented to me.

I further affirm:

(A) that the extent of the procedure and mode of anaesthesia are left to the discretion of the physician.

(B) that any additional surgery or procedure to that described above will only be carried out in necessary and in my best interest and can be justified for medical reasons.

Signature: ..........................             Signature: ...........................
or Thumb print .....................            Full Names: .........................

(Patient or Guardian)                   Address: ......

Date: ...................................                                    (Witness)

Date:.................................

CONSENT FOR SURGERY/PROCEDURES

I further affirm

Article 32 of the Code of Medical Ethics in Nigeria forms the basis of the procedure in disciplinary procedures in breach of medical ethics. It states *inter alia* that; ‘When any aspect or area of professional practice as conducted by a registered practitioner is called to question to the information or knowledge of the Medical and Dental Council of Nigeria, by an aggrieved person or by a colleague, or by any other means whatsoever, that aspect or area of the practice or professional relationship, and any other relevant matters, shall be examined within the context of the provisions of the Medical and Dental Practitioners Act’.

The highlights on procedure from Article 32 of the Code of Medical Ethics in Nigeria 1995 are as follows;

(i) information emanating from an aggrieved person or by a colleague (medical practitioner) or by any other means whatsoever.
(ii) the area of breach shall be examined within the context of the provisions of the Medical and Dental Practitioners Act.

Section 15(1) of the Medical and Dental Practitioners Act establishes the Medical and Dental Practitioners Disciplinary Tribunal and charges that body with the duty of considering and determining any case referred to it. Section 15(3) of that statute establishes the Medical and Dental Practitioners Investigating Panel. The duties of this Panel are important to this chapter. They are as follows;

(a) Conducting a preliminary investigation into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner or dental surgeon.

(b) Compelling any person by subpoena to give evidence before it.

(c) Deciding, if satisfied that to do so is necessary for the protection of members of the public, to make an order for interim suspension from the medical or dental profession in respect of the person whose case they have decided to refer for inquiry, and for the case to be given accelerated hearing by the disciplinary tribunal within three months.

(d) Deciding, if satisfied that to do so is necessary for the protection of members of the public or is in his interest, to make an order for interim conditional registration in respect of that person, that is to say, an order that his registration shall be conditional on his compliance during such period not exceeding two months as is specified, as the panel may think fit to impose for the protection of the public or in his interest.

That Panel performs police functions in the sense that it conducts investigations into allegations against Medical Practitioners. One aspect that deserves some discussion, albeit a brief one is the effect of the powers of the Panel in section 15(3) (c) and (d) of the Medical and Dental Practitioners Act. In both sub-sections the Panel is endowed with the powers to: (a) make an order of interim conditional registration in respect of a medical practitioner.

One the rudiments of law at the adjudicatory state is that a person or even an institution must not be a judge in its own cause. This is the distillation in the time honoured expression, ‘nemo judex in causa sua’. This expression is even more relevant in this situation where the Panel investigates, makes recommendations to the Council and
may still award penalties, although with temporary force. It is an aspect of right to fair hearing. This aspect ought to be reviewed to conform to the decency expected in law since the existence of the Panel is in consonance with the legal control of medical ethics. There are enough judicial authorities to support the view that the Panel, in giving out sanctions after investigating, may itself run afoul of extant law.

This was one of the issues considered in the case of Royal Netherlands Harbour Works (RNHW) v. Sama. [1991] NWLR (Pt 171) 64. In that case, the plaintiff/respondent, a medical doctor acquired 151 acres of land which he intended for building his clinic. Some years later, some preliminary arrangements in the form of intent were made by the plaintiff and RNHW the appellant, to rent and develop approximately 20 acres out of the land. Two years later the plaintiff through his solicitors wrote to the RNHW announcing that he has obtained governor's consent and his readiness to exercise the option to buy over the interest of the RNHW. The RNHW on 8 November replied through their solicitors requesting the plaintiff to execute the deed of underlease. The underlease was never executed by the plaintiff in favour of the RNHW. A year after, the state military administration revoked all rights of occupancy on all parcel of land, including the land in dispute, at Eket Inim in Calabar for public purpose in favour of Nigerian Ports Authority, the 2nd defendant in this matter.

The defendant alleged that the RNHW completed 40 houses on May 1, 1979 went into possession without waiting for the requisite consent under the acquisition of land and that in so doing had waived its right to insist on the need for the said consent and that by newspaper report, the RNHW has sold the property to N.P. A.

The trial judgment was awarded against the plaintiff and the counter claim dismissed. Dissatisfied with the judgment, the defendant appealed contending, inter alia, that the plaintiff is not competent to seek a relief under acquisition of land without attorney-general's consent; that the trial judge being a patron of the plaintiff's hospital which is directly connected with the subject matter of the action is prevented from adjudicating on the matter.

The second appellant (N.P.A), appealed against the aspect of the judgment which tended to threaten its authority to occupy the property which is the subject matter of the action.
It was held, inter alia, that it is trite that a man should not be a judge in his own case—\textit{nemo judex in causa sua}. Consequently, in the instant case, the learned trial judge being the patron of the plaintiff’s medical centre built on the land which formed the subject matter of the action was caught by the Latin maxim and therefore prevented from adjudicating on the matter.

From the contents of section 15(1) of the Medical and Dental Practitioners Act, 2004 the Medical and Dental Practitioners Investigating Panel has no adjudicatory role. The disciplinary procedure for breach of medical ethics commences from the preliminary investigation into any case referred to the Panel. The report of the Panel forms one of the two situations under which the Medical and Dental Practitioners Disciplinary Tribunal may assume jurisdiction on a matter. Section 15(i) provides \textit{inter alia} that the Medical Dental Practitioners Disciplinary Tribunal shall be charged with the duty of considering and determining any case referred to it by the Panel and any other case of which the disciplinary tribunal ‘has cognisance’

From the second schedule of the Medical and Dental Practitioners Act, it is clear that the disciplinary procedures in cases of breach of medical ethics start from the report of the Investigating Panel which is forwarded to the Medical and Dental Practitioners Disciplinary Tribunal. The Tribunal performs adjudicatory functions on matters brought before it in what is referred to as ‘infamous conduct’ as well as acts which constitute professional negligence both being aspects of breach of professional ethics. ‘Infamous conduct’ include acts contained in Rules 1 to 25 of the Code on Medical Practice in Nigeria. In Rule 27(a) (i) of the Code of Medical Practice in Nigeria, the Medical Practitioners Investigating Panel is referred to as ‘court of first hearing in matters of alleged infamous conduct’ while the Medical and Dental Practitioners Disciplinary Tribunal is referred to in Rule 27(b)(i) as having the status of a High Court of the Federal Republic of Nigeria.

Rule 27 of the Code on Medical Ethics in Nigeria proves a wrong nomenclature for the Medical and Dental Practitioners Investigating Panel. This Rule refers to that Panel as a ‘court of first hearing’. As the name implies and judging by its duties as stated in section 15 of the Medical and Dental Practitioners Act, the Panel has investigative powers and not judicial functions. Section 15(3)(a) provides an insight into the main function of the Panel as follows;
'Conducting a preliminary investigation into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner or dental surgeon, or should for any other reason be subject of proceedings before the disciplinary tribunal'.

From this provision, it is clear that the Panel is not seised of judicial functions. What it is allowed to do under the Act is to make preliminary investigation into cases and make recommendations to the Medical and Dental Practitioners Disciplinary Tribunal.

Section 2(1) of the second schedule of the Medical and Dental Practitioners Act endows the Attorney-General of the Federation with the power to make rules as to the selection of members of the Disciplinary Tribunal for the purpose of any proceedings and as to the procedure to be followed and the rules of evidence to be observed in proceedings before the Disciplinary Tribunal. Particularly, section 2(2) of this schedule provides for notices to parties, legal representation and gazetting of the notices of the Disciplinary Tribunal.

While the status of the Panel as a court of first hearing is seriously in doubt, the status of the Medical and Dental Practitioners Disciplinary Tribunal does not attract the same view. This is because it takes evidence from parties, adjudicates on matters, and has powers under section 16 of the Medical and Dental Practitioners Act to sanction members for breach of medical ethics.

In litigation against the Council, matters are usually instituted against the Medical and Dental Practitioners Disciplinary Tribunal and not against the Council.

Firstly, the council has the power to investigate complaints concerning persons registered in terms of the Act. This aspect needs some discussion. It would appear that the council can only investigate complaints laid before it by other persons. By this token, the council does not have the power to bring out complaints *suo motu*. The mischief that this may prevent is to save the Council from the possibility of bias as bringing out complaints by itself may run contrary to the legal rule of fair hearing which is always referred to as *nemo judex in causa sua*. Ancillary to this is that such complaints shall be made concerning persons registered under the Act. By the interpretation of this section, the council has both investigative and disciplinary powers. It is eminently endowed with the authority to mete out disciplinary measures against erring members of the profession.
From the above submission, it can be easily assumed that the council has quasi-judicial functions. In carrying out these functions, it is imperative to observe the rules of natural justice, particularly rules of fair hearing and law of evidence.

One of the duties of law is the protection of citizens within its jurisdiction. That duty operates in two ways. For instance, it operates with a view to protecting the individual against harming himself/herself. The other side to this duty is the protection of the public against the act of an individual or group of individuals.

It is in the latter respect that the endowment of disciplinary powers to the council can be explained. By virtue of this power, the council may take appropriate disciplinary actions against persons in order to ‘protect the interest of the public’. Taking disciplinary actions against persons in the interest of the public has a number of benefits. One of these is that such persons whose acts are considered for disciplinary measure would serve as deterrent to others who may intend to undertake such acts at other times as one of the objects of the law is to prevent the occurrence of socially damaging actions.

Any person may lay complaint regarding any conduct by a registered medical practitioner that breaches any of the following standards:

- a. unauthorised advertising
- b. incompetence in treating patients.
- c. over servicing patients
- d. charging excessive fees
- e. criminal convictions
- f. insufficient care towards patients
- g. improper relationships
- h. racial discrimination
- i. improper conduct
- j. rude behaviour towards patients
- k. performing surgical procedure without patient’s informed consent
- l. prescription of specific medicine to maintain the dependency of a patient.
- m. disclosure of information regarding the patient without his/her permission

9.4.2 Legal viewpoints on breaches of ethics

In all cases of breaches of ethics, patients or their guardians have the option of lodging complaint to the Registrar of the Medical Council.
The complaints go from the investigative process to the adjudicatory stage in both jurisdictions. The Medical and Dental Practitioners Investigative Panel is referred to as a ‘court of first hearing’. By virtue of section 15(3)(a), reference to the Panel as a ‘court’ is greatly debatable as its main duty is to investigate cases of alleged malpractices and make report and recommendations to the Tribunal.

The Medical and Dental Practitioners Disciplinary Tribunal possesses statutory powers to take evidence from parties, evaluate such evidence and met out sanctions.

In carrying out its duties the Tribunal is expected to follow laid down procedure within its enabling statutes and the constitution.

Indeed the most important of this is the issue of fair hearing in handling of complaints on breach of ethics. In this respect, section 36(1) of the Constitution of the Federal Republic of Nigeria 1999 articulates the constitutional standpoint.

It provides that: ‘In the determination of his civil rights and obligations, including any question or determination by or against government or authority, a person shall be entitled to a fair hearing within a reasonable time by a court or other tribunal established by law and constituted in such manner as to secure its independence and impartiality.’

This section is replicated in section 34 of the Constitution of the Republic of South Africa, 1996 which provides as follows;

‘Everyone has the right to have any dispute that can be resolved by the application of law decided in a fair public hearing before a court or, where appropriate, another independent and impartial tribunal or forum’.

The Supreme Court of Nigeria gave a prudential view of section 36 in the case of Garba & Ors v University of Maiduguri & Ors. (1986) 1 NWLR 550 at 584. This case arose from the University of Maiduguri after a students’ demonstration. The Deputy Vice-Chancellor was attacked and his house was burnt. The demonstrators committed arson, destruction of property etc. A panel was set up which was referred to as the Disciplinary Investigation Board. This Board included the Deputy Vice-Chancellor whose house was burnt. This was challenged by the students. In giving judgment on appeal from the Court of Appeal, the Supreme Court held inter alia that there was the necessity for compliance with the rules of natural justice, audi alteram partem and nemo judex in causa sua. The court also decided that the rules of natural justice as provided in section 36 of the
Constitution of the Federal Republic of Nigeria must be observed in any adjudication process by any court or tribunal established by law.

By this token, the Medical and Dental Practitioners Disciplinary Tribunal being an establishment of the law must observe fair hearing in all its processes otherwise, decisions arrived at may be set aside by the court. This occurred in previous cases against the then Medical and Dental Practitioners Disciplinary Committee.

In *Denloye v Medical and Dental Practitioners Committee* (1968) 1 All NLR 306, the Supreme Court of Nigeria held that while the tribunal had power to decide on its own procedure and lay down rules for the conduct of enquiries regarding discipline, it was of the utmost importance that the enquiries be conducted within the rules of fair hearing and natural justice. In the instant case, the tribunal had withheld the nature of the evidence against the appellant from him.

The complaints against the appellant were about demanding and receiving bribes from patients along with various acts of extortion. The Tribunal in carrying out its duties went behind the appellant to obtain evidence and held meetings at the residence of the complainant.

In spite of the overwhelming evidence against the medical practitioner in that matter, the decisions of the Tribunal were reversed by the Supreme Court.

In *Alakija v Medical Disciplinary Committee* (1959) 4 FSC 38, it was canvassed, among other issues that the Registrar was present in the Committee’s deliberation after the respondent and his legal representative had left the meeting. The Registrar was the prosecutor in the case. The Supreme Court of Nigeria held that the Registrar was not entitled to be present when the committee was having its deliberation. For this reason, the decision of the committee was set aside.

One case that brought out a different dimension in the legal viewpoint on breaches of ethics is that of *Sofekun v Akinyemi* (1980) All NLR 153. In that case, the appellant had been tried and found guilty of various acts of misconduct in the employment of the Public Service Commission.

There were accusations of acts of misconduct which included indecent assault, carrying out a vaginal examination in an unorthodox fashion and doing same without a third party. The provisions under which the inquiry took place were provided for by the amendment of Public Service Commission to inquire into the criminal offences
committed by employees with a view to employing disciplinary measures against them. The appellant was found guilty and dismissed from service thereon.

At a seven panel sitting of the Supreme Court of Nigeria, it was decided as follows:

a. Once a person is accused of a criminal offence, he must be tried in a court of law, where the complaints of his accusers can be ventilated to ensure getting a fair hearing as set out in section 22(4) to (10) of the Constitution of the Federal Republic of Nigeria 1960. No other Tribunal, Investigating Panel or Committee will do.

b. If Regulations such as those under attack in this appeal were valid, the judicial powers could be wholly absorbed by the commission and taken out to the hands of the judiciary. The jurisdiction and authority of the courts of this country cannot be usurped by either the Executive or the Legislative branch of the government under whatever guise or pretext whatsoever.

The decision in this case remains the law in Nigeria and with this, it is doubtful if allegations of crime like those raised in the Sofekun’s case can be handled by the Medical and Dental Practitioners Disciplinary Committee. At best, the committee may take evidence from complainants after investigation reports from the Medical and Dental Practitioners Investigating Panel. The next thing might be that the Tribunal will look into unethical acts and refer the Criminal ones to the Police for investigation. This is because one of the issues raised by the appellant and accepted by the Supreme Court in the Sofekun’s case was that allegations of crime must be proved beyond reasonable doubt. Section 138 (1) of the Evidence Act Cap E14 Laws of the Federation of Nigeria 2004 provides as follows: 'If the commission of a crime by a party to any proceeding is directly in issue in any proceeding civil or criminal, it must be proved beyond reasonable doubt.' This section was interpreted in *Ede v Federal Republic of Nigeria (2001) FWLR (Pt 81) 1834 at 1836* as follows; ‘A proof beyond reasonable doubt means that in law and in fact, there is proof that an accused committed the offence with which he was charged’. This was stretched further in the case of *Agbo v State (2006) 1 SC (Pt II) 73* where the Supreme Court of Nigeria, citing with approval the dictum of Denning J in *Miller v Minister of Pension (1947) 2 All ER 372* at 373 had the following to say: ‘Proof beyond reasonable doubt does not mean proof beyond the shadow of a doubt. The law would fail to protect the community if it admitted fanciful possibilities to deflect the course of justice. If the evidence is so strong against a man as to
leave only a remote possibility in his favour which can be dismissed with the sentence, of course it is possible, but not in the least probable, the case is proved beyond reasonable doubt but nothing short of that will suffice’

One of the most controversial cases on breach of medical ethics in recent times in Nigeria is the case of Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo [2001] FWLR (Pt 44) 542. This case touched on breach of medical ethics and procedure of adjudication by the Medical and Dental Practitioners Disciplinary Tribunal.

After passing through the Tribunal to the Court of Appeal and finally to the Supreme Court of Nigeria, it can be referred to as the locus classicus on the legal viewpoint of breaches of medical ethics in Nigeria.

The relevant facts of this case were that a certain lady had been delivered of a child. She was admitted to the hospital of a certain Okafor after about one month after the delivery. She had difficulty in walking and severe pain in the pubic area. The clinical diagnosis showed a severe ailment which necessitated her admission and made blood transfusion an imperative.

Both the patient and her husband refused blood transfusion on religious grounds being members of a Christian Religious sect known as Jehovah’s Witnesses which regards blood transfusion as forbidden by God. Dr. Okafor issued the patient a certificate of discharge whereupon she was taken away by her husband. She was then taken to Jeno Hospital, Lagos which belonged to Dr. Okonkwo, the respondent in this matter. Being a member of the Jehovah’s Witnesses as well, Dr. Okonkwo proceeded to treat the patient without blood transfusion. The patient died a couple of days thereafter.

Dr. Okonkwo was charged before the Medical and Dental Practitioners Disciplinary Committee on two counts.

In the first count, he was charged with attending to the patient in a negligent manner and thereby conducting himself infamously contrary to ‘medical ethics’. In the second count, he was charged with acting contrary to his oath as a medical practitioner and thereby conducting himself infamously in a professional respect.

The allegations in the two counts were:
1. that the respondent (Dr. Okonkwo) “made no plans and in fact failed to transfuse blood to the patient until she died”.

2. that the patient failed to transfer the patient to a bigger centre where such inhibition would not operate to the ‘patient’s disadvantages’

3. it was clear that only blood transfusion could possibly save the patient’s life but because of his religious belief against blood transfusion, he ‘readily agreed with the patient’s husband not to transfuse blood, even when the patient’s relations pleaded with the respondent to the contrary.

4. There was evidence before the tribunal that the responded had transfused blood to other patients of that religious sect who agreed and one of the late patient’s relations was detailed to keep watch on the patient lest she be overpowered and blood transfused into her.

After taking further evidence in the matter, the tribunal found the respondent guilty of the charges and suspended him for a period of six months on each of them. One of the grounds for conviction by the tribunal was the failure of the respondent to give the correct treatment in the face of failure to obtain consent.

The Court of Appeal set aside the decision of the Tribunal for which reason the Tribunal proceeded to the Supreme Court of Nigeria. At that court, twenty-six rationes were given as setting judicial precedent. The relevant ones to this work are as follows:

1. Where the unprofessional conduct of the medical practitioner amounts to a crime, it is a matter for the court to deal with. (This had been decided much earlier in Sofekun’s case)

2. It is clear that the Tribunal is set to try specified offences under its Act. It has no jurisdiction to try criminal offences at large.

3. The function of the Tribunal is to consider and determine any case referred to it by the Investigative Panel.

4. The function of the Medical and Dental Practitioners Investigative Panel is to conduct preliminary investigation into any case where it is alleged that a registered person has misbehaved in his capacity as a medical practitioner.

5. Where infamous conduct cannot be established without proving facts that would amount to an offence under the Criminal Code, the Tribunal should yield to the criminal courts established for the trial of such offence.
6. Every infraction of the Code of Ethics does not amount to infamous conduct in any professional respect and a medical practitioner is the judge of the choice that may be best for treatment.

This case elucidates the Nigerian legal viewpoint on breach of ethics and indeed the need for a thorough review of the Medical and Dental Practitioners Act. Another area worthy of mention regarding legal overview of breach of ethics in Nigeria is negligence. A person is deemed to be negligent when he or she omits to do something which a reasonable man would do when he is guided by the factors which ordinarily regulate human conduct or when he/she does something which a prudent and reasonable man would not do *Aliyu v Aturu* [1999] 7 NWLR (Pt 612) 536. With respect to medical practice, negligence would consist in the breach of a legal duty which leads to damage. *Okin Biscuit Ltd v Oshe* [2004] FWLR (Pt 188) 1094.

Acts that constitute professional negligence Rule 28 of the Code on Medical Practice in Nigeria 1996 include the following;

(a) failure to attend promptly to a patient requiring urgent attention when the practitioner was in a position to do so.

(b) manifestation of incompetence in the assessment of a patient.

(c) making incorrect diagnosis particularly when the clinical features were so glaring that no reasonable skilful practitioner could have failed to notice them.

(d) failure to advise or proffering wrong advice to a patient on the risk involved in a particular operation or course of treatment especially if such an operation or course of treatment is likely to result in serious side effects like deformity or loss of organ.

(e) failure to obtain the consent of the patient (informed or otherwise) before proceeding on any surgical procedure or course of treatment when such consent was necessary.

(f) making a mistake in treatment e.g. amputation of the wrong limb, inadvertent termination of pregnancy, prescribing the wrong drug in error for a correctly diagnosed ailment.

(g) failure to refer or transfer a patient in good time when such a referred or transfer was necessary.

(h) failure to do anything that ought reasonably to have been done under any circumstance for the good of the patient.
(i) failure to see a patient as often as his medical condition warrants or to make proper notes of the practitioner’s observations and prescribed treatment during such visits or to communicate with the patient or his relation as may be necessary with regards to any developments, progress or prognosis in the patient’s condition.

Negligence, as a breach of ethics in medical practice, could arise out of the contract between the patient and the medical practitioner. The contract arises after the payment for the clinic consultation card after which the medical practitioner is bound to attend to the patient and provide the choice of treatment depending on diagnosis. A medical practitioner would be liable for negligence to a patient in the following instances among others:

a. Failure to give proper and timeous instructions to the patient or his/her guardian.
b. Failure to provide information for continued medical treatment to both the patient and future physicians
c. Failure to sterilize medical equipment
d. Administration of drugs without proper diagnosis
e. Forgetting to remove the scalped, scissors, cotton-wool or other things from the patient before stitching up the body
f. Transplanting organs without checking the blood group and genotype of the donor and done
g. Transplanting an organ from an ailing patient to another.

These instances are nearly inexhaustive but one common decimal amongst them all is that they may give rise to a civil action for which the medical practitioner may have to pay damages. This occurs when a civil action is instituted against the practitioner at the civil court and has nothing to do with a complaint laid before the Medical and Dental Practitioners Council. The Council does not have the powers to award damages or order parties to pay compensation.

It is noteworthy that in Nigeria, matters like this rarely go to the civil court and rarely too are reports made to the Medical Council as matters are settled between the Medical Practitioners and Parties who usually accept the fate of the patient howsoever it is.

It is the life of the citizen that the law seeks to protect by providing legal viewpoints on breaches of ethics.
In the first instance, there is the ethical duty on the medical practitioner to obtain consent for any treatment or operation that may be carried out on the patient.

Consent applies to all bodily contact with the patient, breach of which would amount to an assault. Clearly, where a patient obtains a clinic card and seeks for a routine check, consent is implied. Accordingly, taking of blood pressure with the sphygmomanometer cuff after rolling up the sleeves of a patient might not be in breach of the ethical duty of the medical practitioner particularly if the patient gave cooperation. Understandably, more caution would be required of the patient in cases of examination of more compromising parts of the body like the genitals and breasts.

9.5 Remedies
The medical practitioner’s culpability for a breach can be classified into two categories. This is criminal and civil culpability respectively. Criminal culpability arises where the breach is any act which might be seen as a crime. In this regard, it would include murder, manslaughter or negligent acts. All of these are crimes which can be prosecuted by the state only against the medical practitioner.

As for civil culpability, the effect of this can only manifest damages for injuries to the patient due to negligence in treatment or surgical operations or breach in any other form.

To sustain a charge of murder, it must be proved that by a person’s act or omission, he or she intended to cause death or grievous bodily harm or that the act which caused the death was likely to endanger human life and was done in the prosecution of an unlawful purpose. This was the decision in *Mohammed v State NCC* (2007) Vol. 2 page 574.

It is doubtful if a charge of murder would be sustained against a medical doctor in the treatment of a patient under these circumstances. Be this as it may, the remedy is of no advantage to the patient as it is only in terms of death by hanging or life imprisonment which can never revive the deceased patient.

The remedy that may bring direct advantage to the patient in the case of a breach is in terms of damages. In the *Okekearu v Tanko* [2003] WRN Vol. 28 SC 71, the facts were that the plaintiff, in the course of removing some zinc from his mother’s residence injured his left centre finger. The wound was not deep but neighbours insisted on taking him to the hospital.
The defendant without due care and skill negligently amputated the finger. This permanently disfigured and incapacitated the plaintiff in handling objects. The defendant medical doctor denied this but stated that at the time the plaintiff was brought to him, the distal portion of the finger was almost completely severed from the carpals except for a shred of skin. He also claimed that the bone in the distal part was broken and the reasonable medical option was to trim off the skin amputate and dress it. This he claimed, were in consonance with standard medical practice.

At the High Court, the plaintiff was awarded the sum of ₦100,000 as damages. The defendant medical doctor appealed against this judgment to the Court of Appeal. That court reduced the damages awarded to ₦50,000. Yet dissatisfied, the plaintiff/appellant appealed against that judgment to the Supreme Court of Nigeria. That august court upheld the decision of the Court of Appeal.

The inference that can be drawn from this case is that the damages awarded are usually minimal and far below the extent of damage. By all means however, damages are the main remedy that can be obtained in the event of a breach.

It is indubitable that there is no scale for damages. While it is must be admitted that through damages, the law through the courts attempt to assuage the wrong done on a sufferer, there are no scales by which the pain and suffering can be calculated and there may never be any judicially accepted relationship between pain and suffering on one hand and damages on the other hand.

The main duty of the medical practitioner is to take care of the patient in accordance with standard medical practice. In all situations of relationship between the medical practitioners, the practitioner must act in the best interests of his or her patients. This is usually referred to as beneficence. It may also be referred to as physician paternalism. The Code of Medical Ethics in Nigeria provides sufficient information in this respect. In its introductory part, the Drafters, Medical and Dental Council of Nigeria express their desire that every medical and dental practitioner should familiarise himself or herself with the provisions of the Code.
The latent effect of the Code is to enhance the image of the medical profession, increase the confidence of the public in the medical practitioner and offer protection to the conscientious practitioner.

The case of Nigeria, the Medical and Dental Practitioners Disciplinary Tribunal performs the same functions. The status of that Tribunal is equal to that of the High Court of any jurisdiction in Nigeria.

Mr Vice Chancellor and my distinguished audience, I have provided this elaborate background in order to ground the impression that there is the need for a legal regimen for the transplantation of human organs in Nigeria which must be all inclusive and comprehensive. The concluding remarks hereafter provide the panacea to this current nebulous situation.

10.0 Suggestions and Concluding Remarks

10.1 Medical ethics arose from the Hippocratic Oath. The Oath formed the basis and rudiment of medical practice. It formed the basis for the Geneva Declaration. Both the Hippocratic Oath and the Geneva Declaration consist of a broad spectrum of issues in medical practice in general and transplantation of organs in particular. For instance, issues on patient confidentiality, removal of organs, foetal test, conflict of interest and rights of patients among others feature prominently in these documents.

From all these, ethical values which inform judgement in medical practice have arisen. These include beneficence, non-maleficence, autonomy of the patient, dignity of the patient and the practitioner, honesty to the patient and clinical judgment. These values underscore medical practice and they form the pillars particularly in matters of transplantation of organs.

Medical judgment is the endpoint of any interaction between the medical practitioner and the patient. This can only come up after a medical interview. In making a clinical judgment, the medical practitioner is guided by this ethical values and it is safe to assume that these values form the framework in taking medical decisions. There is no single composite law for all these various areas of medical practice which are major issues in transplantation cases. Transplantation of organs, such as kidney and liver, is without legal control hence the need for rules of practice, preferably in a statutory form, in this respect rather than ordinary general provisions on removal, use, allocation and donation as contained in the National Health Act of 2014.


10.2 Transplantation, being a new frontier in medical knowledge and practice has given rise to new issues relating to consent, procurement, commercialisation and organ banking. All these make the emergence of a legal regime that is quite different and mutually exclusive to human organ transplantation an imperative. These aspects of transplantation call for legal control. For instance, the issue of consent is important. By all means, in both the living and cadaveric cases of donation, it must be voluntary. This may not be difficult to prove in living donations but it may require strict legal backing in cadaveric donations. Donations from cadaveric sources provide two regimes. These are the ‘opt in’ method and the ‘opt out’ method. Through the ‘opt in’ method, a donor gives explicit consent while in the ‘opt out’ method, it is assumed that a person who has not refused is a donor. Consent to remove an organ must be sought and obtained from the donor and from the recipient; consent must be sought for an organ to be transplanted. Once the consent of both parties has been sought and obtained, then the parties’ constitutional rights to privacy, liberty and dignity would have been deemed respected and protected. These are constitutional rights that can only be voluntarily waived by the parties respectively. The right to personal liberty, dignity of human person and privacy of the individual are protected under sections 35, 34 and 37 of the Constitution of the Federal Republic of Nigeria 1999 respectively.

10.3 For the fact that the law gives freedom to choose whether to donate an organ or not, there is a limited source of procurement of organs from human beings. One source of procurement of organs is through commercialised organs. In concise terms, a commercialised organ is that which is sold by the owner for monetary gains rather than altruistic reasons. This is illegal. There are specific sanctions against the sale or trade in organs as contained in section 53 of the National Health Act, 2014. Allowing the free trade of organs will make them available, save lives and possibly boost the economy of some nations but such a practice would ultimately be against the right to dignity of the human person. This can only be juxtaposed against the autonomy of the person, that is, the right of the person to do whatever he/she likes with the organs in his/her body.

10.4 The best option for the procurement of an organ is the cadaveric source. This aspect is however surrounded by controversy which stems on the point at which a
person can be declared dead. ‘Brain death’ is the common expression for this phenomenon.

The adoption of death as ‘brain-death’ appears to provide some succour in the determination of death. A practical definition of brain death is when a person feels no pain or gag responses, negative caloric ear testing, and has flat EEG. The controversy on the legal and medical definition of death rages on.

The controversy on ‘brain-death’ is important because of donations after the death of a person where organs may be removed for the purpose of transplantation into other persons or research purposes.

The circumstances that exist for the determination of death appear to have been narrowed down to ‘irreversible cessation of circulatory and respiratory functions’ and ‘irreversible cessation of all functions of the entire brains, including the brain stem’. In spite of all these attempts at determining the characteristics of death, the particular period when these circumstances occur will continue to be nebulous despite the advancement in medical practice.

In all these processes there are bound to be breaches. It is in this respect that law comes in to provide control and perhaps a legal regime over this intricate but important aspect of medical practice. In this regard, statutes are not comprehensive in Nigeria. This brings to the fore the Dworkinian approach to law which is referred to as legal paternalism. By this approach, the requirement by law of certain duties from the medical practitioner in his/her duties is justifiable even when it has the result of curtailing the rights of the medical practitioner. The zenith of this approach is the enforcement by law of ethical codes and oaths which provide respect for dignity and liberty of the human person in medical practice in general and highest standards in transplantation of organs in particular.

This is done in general terms in some laws. Some of these include the Criminal Code Act, the Constitution of the Federal Republic of Nigeria 1999 and the Medical and Dental Practitioners Act. The Medical and Dental Practitioners Act establishes the Medical and Dental Practitioners Disciplinary Tribunal which considers matters of breach of ethics and practice by members of the profession.

As it can be noticed, all the pieces of legislation earlier cited have relationship with medical practice in general. None of them is specific on transplantation of organs except
the tangential reference in the National Health Act, 2014 to donation of organs and consent to donate. The importance of this work is hinged on the need to develop a legal framework for the transplantation of organs.

10.5 As was noted earlier in this lecture, the controversy on the definition of death continues. This issue is important because except in live donations, organs cannot be removed from a person until the certification of death. In any case, the ideal organ donor is one that cannot be harmed by donation.

The idea of brain death is deeply ingrained into medical practice for anyone to suggest that it be abandoned. What ought to be done in the prevailing circumstances is to attempt a more encompassing legal definition for the phenomenon. It is with this approach that we can assume a safe situation where the lives of persons will not be wasted on the probability of death.

This is expedient in order to assist the medical practitioner and other interested parties in determining the point at which a person could be said to be dead. This does not help in determining death by way of criteria in arriving at the definition of death for the purpose of removal of an organ for transplantation. Admittedly, technological incursion into medical practice may make adoption of fixed criteria impossible but this does not subtract from the fact that it is necessary to define ‘death’ in a statutory document.

If the use of CPR (cardiopulmonary resuscitation) is considered, it will even be more difficult to arrive at an all-encompassing definition of ‘death’. For instance at the cessation of cardiopulmonary functions, the person may be assumed dead particularly when the pulse ceases momentarily. Technologically, life saving devices (Ispd) and cardiopulmonary resuscitation (cpr) may assist in prolonging the life of a person. It is also dangerous to rely completely on the principle of accepted medical practice for the determination of death. This is even more pertinent because persons with irreversible coma and apnoeic seizure could be regarded as dead even before cessation of heartbeat notwithstanding the possibility that life could be sustained and prolonged by life saving devices (Ispd) and probably revived through the successful administration of drugs.
For this reason, it is imperative to have a working and statutory definition of death in order to serve as a guide to the medical practitioner, the patient and relations of the patient.

The need for all these is all the more potent for the following reasons;

a. to determine the time at which life sustaining devices (lsd) may be withdrawn from the patient.

b. to determine the stage at which the practitioner may proceed to remove organs from the body of a deceased for the purpose of transplantation into another person

c. to avoid the commission of a criminal offence of manslaughter, attempted murder or manslaughter by the medical practitioner

d. in order that the medical practitioner and his/her employers may not be liable in damages to the family of the deceased.

It is recommended that, death must be determined by three medical practitioners, all concurring on that situation. With these two provisions in a statute, the possibility of error and waste of human life will be reduced while at the same time, the removal of an organ for the purpose of transplantation will be increased. This would help people with end stage diseases and give better quality of life and less cost to medical expenses.

10.6 Organ banking is all about a statutorily recognised institution where organs may be preserved for use. The bank in reference would be a pool where organs are preserved for use for therapeutic reasons as well as research.

The need for an organ bank cannot be overstated. By all means, where it exists, it serves as a repository of organs for patients. In view of the fact that the organs are kept there for therapeutic and research purposes, for human beings, there is the need to regulate the existence and administration of this bank. This is more necessary because whether for therapeutic or research purpose, the organ is used by human beings for productive purposes. These include replacement of ailing or failed organs and research into the physiology of the human being, among other purposes. With this background, it is clear that the government should be involved in the administration of an organ bank and such a bank must not be established by an individual but rather by an institution or a juristic person.
It is recommended that such a bank must be registered with the Ministry of Health. A preliminary factor for registration is that it must be a juristic person, a healthcare institution or research institution. After having satisfied one of these factors, the bank should operate under the full control of the Minister of Health.

The following documents shall be submitted by the promoters of the bank to the Minister of Health who shall vet and approve or disapprove their establishment.

(a) certificate of incorporation or where it is a government institution, the enabling statute
(b) the name, address and other descriptions of the bank
(c) equipment and facilities available to the bank at the commencement of business.
(d) quality control and management of organs
(e) curriculum vitae of the Medical Director and Quality Director

These are certain criteria that ought to be considered before registration. These are imperative particularly to ensure the overall quality of the organs and utility value of the organs in recipients and non-maleficence in donors. Where these considerations do not exist then the essence of the bank may be defeated.

There are many ways of controlling the quality of the organs. The first however is the employment of the right personnel in terms of experience.

For instance, it is necessary to appoint as the head of the bank a physician who shall be referred to as the Medical Director, with practical experience in transplantation, basic or clinical immunology, and haematology. With this qualification, his responsibilities will include;

a. reviewing the suitability of organ donors
b. reviewing the release of human organs.
c. recommending the utility of human organs to physicians for recipients
d. validating medical standards of organ preservation
e. arranging seminars and workshops on organ banking and organ transplantation
f. informing procurers of the effects of organ transplantation.

In order to further strengthen the quality of the organs, it is recommended that the Medical Director be assisted by a Quality Director who must be a physician, surgeon or a postgraduate person in Biology. The functions of that office should include;

a. establishing and maintaining the quality management system of the organ bank
b. providing a frequently updated standard for the preservation of organs.
c. ensuring temperature and humidity control as well as the instruments, labelling and packing of organs.

In order to fulfil the ethical aspects of organ preservation, there is the need to have, at least, a certificate of consent from the donor. The issue of consent is all the more important having in mind the provision of Guiding Principle 3 World Health Organisation, Guiding Principles on Human Organ Transplantation 389. It provides that ‘Organs for transplantation should be removed preferably from the bodies of deceased persons. However, adult living persons may donate organs, but in general, such donors should be genetically related to the recipients’. It further provides that ‘An organ may be removed from the body of an adult living donor who gives free consent. The donor should be free of any undue influence and pressure and sufficiently weigh the risks and benefits of the consent’.

In this respect, it also necessary for the certificate to include the suitability of the donor to donate and a fact sheet from the recipient’s physician indicating that he/she is in need of the organ. This aspect of the certificate would give an assurance that, for instance, the donor is not suffering from any ailment that may affect the utility or quality of the organ in the recipient. In the case of an imported organ, a document evidencing of importation will suffice.

Further into the issue of ethics, the personnel of the bank should not disclose the information on both donors and recipients or others, received by virtue of their jobs, records or documents or duties unless as directed by a court through an order.

In view of all these, what is recommended is an Organ Bank which is a creation of a statute with the *modus operandi* of the Bank clearly stated. Accordingly, in the suggested document, the standards of preservation must be stated, the personnel of the bank will be statutorily provided and the role of the various health associations will be provided.

If all these are put in place, it will provide a starting point for an organ bank. It would also serve as the basis for future development in this matter for the benefit of human beings.

Commercialisation of organs is a factor of non-availability of the organs and poverty in some nations. Generally, commercialised organs are procured from illicit sources. The
source, in this respect, would have given out his/her organ for pecuniary reasons instead of altruistic reasons.

The presence of a growing middle class, the growing disparity between the rich and poor and to some extent, the presence of technology make the process of commodification of organs a simple, quick and attractive business proposition for persons who fall into the lower economic ladder of the society. The issue is ‘why donate when you can buy?’ At all events, there are economically disadvantaged persons willing to sell.

In the field study conducted by Goyal et al (2002:1593) it was found out that in developing countries like India, selling a kidney does not lead to a long-term economic benefit and it may, in fact, be associated with decline in health. The point to be brought out of this is that when organ donation is used as a source of income, donors should realise that it is a major surgical operation which deprives the donor of an innate gift. This deprivation is associated with inherent risk, particularly health wise and it may still not assuage the financial challenge that necessitated the sale.

This concern is worldwide and after it caught the attention of nations, it became reduced to an injunction in the Guiding Principles of the World Health Organisation. Those principles state that ‘The human body and its parts cannot be subject of commercial transactions. Accordingly giving or receiving payments (including any other compensation or reward) for organs should be prohibited’. This aspect is aimed at tackling traffic in human organs for pecuniary advantage.

Subjecting organs to commercial transactions may effect unjust pressure on the poor. Undoubtedly, it would affect the altruistic viewpoint on donation and invalidate the freewill (otherwise referred to as consent) of the donor to donate an organ. In economic terms, it may lead to organs going to the highest bidder and a violation of equity against the ability to pay rather than the medical need for determining distribution of organs. These are all ethical issues which may simply fall flat on the face of the concept of autonomy. By this concept, a person may do as he/she wishes with his body. This includes donating an organ of the body as a way of expressing control over one’s body. The only positive side to this is that organs will be more available in the market to those who can afford the price.
The idea of establishing a market for organs is now attracting attention. Such a market could be effectively regulated and sellers would greatly benefit from the windfall. Both sides of the argument have their positive effects. For instance, it is unconscionable for the state to allow its citizens to sell their organs in order to augment their living. As well, in line with the hardcore doctrine of legal paternalism the state has the duty of providing for the welfare, good and happiness of its citizens. All these have to be juxtaposed against the supply and demand indices of organs.

At the preamble of the Draft of the Guiding Principles on Human and Organ Transplantation, the World Health Organisation noted that a feature of organ transplantation since its commencement has been the shortage of available organs. The organisation also noted that supply has never satisfied demand for which reason there is an increase in commercial traffic in human organs, particularly among living donors who are unrelated to donors.

With this admission from such an eminent source, it is necessary to take a different look at the issue of commercialisation of organs. Without prejudice to extant international statutes and local statutes, it is suggested that the government should put in place an open market for the sale of organs with the criteria that sideline pecuniary gains. For instance, when a donation is clearly for altruistic reasons, aside any statutory reimbursement, the donor ought to be entitled to lifelong free medical treatment in view of the deprivation of the organ. This would include periodic provision of money in the case of special diets. This should be clearly distinguished from bulk sum payment as if the organ was purchased from a market. It could also be by way of compulsory employment for the donor’s offspring who are eligible or tax holiday but definitely not in the form of raw money like purchase at a supermarket. There is the need for a legislation which would stipulate that the donor be rewarded. What ought to be noted and considered is that legitimising the sale of organs and providing reward for donation will reduce incidents of human trafficking for organs.

The corollary to this is the deregulation of the sale of human organs. The immediate effect is the creation of a marketplace for the sale of organs through controlled criteria which would provide a novel socio-legal concept into the constitutional and medical jurisprudence of Nigeria. This would in turn establish the following;
a. competent and trusted system controlling the sale and procurement of organs to completely reduce prejudice to the seller while as well protecting the purchaser.

b. absolute reliance on quality control measures by way of medical competence as well as trusted clinical environment in the process of sale, procurement and use of organs.

c. whittle down the illicit trade in organs in both jurisdictions.

There is the immediate need to make a distinction between illegal trafficking in organs and human trafficking for the purpose of removal of organs. At all events, what should occupy an important place is the prohibition of financial gains from the sale of human organs. Some of the constraints in this respect may include the lack of information on organ trafficking cases and coordination by nations. This can be tackled and brought to control by the establishment of a government agency on Organ Trafficking.

Section 32(A) of the Criminal Code which makes provision specifically for possession of human skull. In view of the fact that the section does not mention human organs, illegal possession of human organs does not fall within its purview. The Nigerian Trafficking in Persons Law Enforcement and Administration Act 2003 is specifically on human trafficking. In view of the fact that trafficking is one of the sources of procurement of organs, this law may reduce organ commercialisation.

Article 6 (c) of the Istanbul Declaration 2008 is clearly against practices that induce vulnerable individuals to become living donors. This Declaration contains comprehensive provisions on commercialisation of organs which ought to be adopted and enforced by South Africa and Nigeria in a separate statute. The challenge to this is the status of international law in a domestic jurisdiction. Nations generally loathe the idea of submitting their sovereignty to either international law or to the sovereignty of other nations. This is understandable because nations are assumed to be equal, one to the other.

One important point is that International Law leaves it to states to adopt such legislative and other measures, consistent with their constitutional processes, to give effect to obligations which they undertake to implement. There are constitutional provisions on the status of an international document like a treaty, declaration or protocol. Such a document will only be enforceable after it has been adopted by the National Assembly.
What is recommended in this regard is the adoption of the Declaration of Istanbul on Organ Trafficking and Transplant Tourism 2008 into the domestic laws of Nigeria. This approach was suggested by Smith in his criticism of the judgement of the Supreme Court of Nigeria in the case of *Abacha v Fawehinmi* (2001) 6 NWLR (Pt 660) 228. In that publication, the author suggested the domestication of the African Charter within Nigerian jurisdiction without reservation. The same thing is being recommended in this work. In essence, the recommendation on commercialisation of organs is the complete adoption of the Istanbul document.

With this recommendation in place, the right to dignity as provided in section 34 of the Constitution of the Federal Republic of Nigeria 1999 can be ensured.

10.7 It is one thing for these recommendations to be codified, it is another thing for them to be implementable. In terms of implementation and recognition, two sets of problems strike at the root of international documents. The first of these arise from the fact that law-making powers are vested in the legislature and rarely in the executive except as delegated by the legislature. Where there is such delegation, such powers must not be exercised outside constitutional provisions. The second issue is that treaty provisions are often general in character. They are unlike specific codes or statutes that exist in municipal law.

One of the factors against the implementation of these recommendations is in chapter II of the Constitution of Nigeria,1999.

10.8 The whole of chapter II of the 1999 Constitution of the Federal Republic of Nigeria is titled, ‘Fundamental Objectives and Directive Principles of State Policy’. Section 17(1) of that document provides that ‘The state social order is founded on ideals of Freedom, Equality and Justice’. In furtherance to this, section 17(3) (d) provides that: ‘The state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons. This is one of the provisions of section 17 which refers to the Social Objectives of the state enshrined in the Constitution of the Federal Republic of Nigeria 1999. In section 6(6)(c) of that document, it is provided that the judicial powers vested in accordance with the Constitution shall not, except as otherwise provided by the Constitutional extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or judicial decision is in
conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of the Constitution.

This aspect of the Nigerian Constitutional law was interpreted in the case of *Archbishop Olubunmi Okogie v. Attorney General Lagos State* (1981) 2 NCLR 337. In that case, the Court of Appeal emphasised the import of chapter II thus:

“The fundamental objectives identify the ultimate objectives of the nation and the directive principles lay down the policies which are expected to be pursued in the efforts of the nation to realise the national ideals. While section 13 of the Construction makes it the duty and responsibility of the judiciary among other organs of government to conform to and apply the provisions of chapter II, section 6(6)(c) of the same Constitution makes it clear that no court has jurisdiction to pronounce any decision as to whether any organ of government has acted or is acting in conformity with the Fundamental Objectives and Directive Principles of State Policy. It is therefore clear that section 17(3)(d) is not enforceable in any court in Nigeria.”

Although not on the social objective of health, the case of the Attorney General of Ondo State v. Attorney General of the Federation and 36 others (2002) FWLR (Pt 111) 1972 was on the interpretation of section 15(5) of chapter II of the Constitution of the Federal Republic of Nigeria 1999. That section provides that ‘The state shall abolish all corrupt practices and abuse of power’. In arriving at its decision, the Supreme Court of Nigeria utilised sections 4(2) and 5(5) of the 1999 Constitution and decided that in order to enforce section 15(5), there was the need to put a law in place and that exactly was what the National Assembly had done by promulgating the Corrupt Practices and Other Related Offences Act of 2000. Guided by the decision in the case of the Attorney General of Ondo State v Attorney General of the Federation and 36 Others (2002) FWLR (Pt 111) 1972, the Supreme Court of Nigeria held inter alia in *Olafisoye v Federal Republic of Nigeria* (2005) 5 WRN 21 that: ‘The non-justiciability of section 6(6)(c) of the Constitution is neither total nor sacrosanct as the subsection provides a leeway by the use of the words, ‘except as otherwise provided by this Constitution’. This means that if the Constitution provides in another section, which makes a section or sections of chapter II justiciable, it will be so interpreted by the courts.

The pragmatic inference to be drawn from the cases of *Attorney General of Ondo v Attorney General of the Federation and Others* (2002) FWLR (Pt 111) 1972 and
Olafisoye v Federal Republic of Nigeria (2005) 5 WRN 21 is that the Nigeria Government must be responsive to remove health from a social objective to a right. In other words, the right to health should be inserted into chapter IV of the 1999 constitution which deals with Fundamental Human Rights. In this respect, it should be borne in mind that democratic leadership and responsive governance are identified by the unwavering protection of the citizenry and any deviation would create a variance from democratic principles; constitute an affront to justice, equity and good conscience and be completely against the paternalistic role of the law and state.

This line was toed in the Indian case of Jain v State of Karnataka AIR (1992) Sup Ct 1858-1864 (App 6) where the Supreme Court held that the right to life necessarily includes the right to a means of livelihood, as well as other rights that make enjoyment of the right to life meaningful. It is submitted that the right to health will make life meaningful and enjoyable to all.

A consideration of the case of Panacy v State of West Bengal (1988) LRC (Const.) 241 would have probably given the decision in the Soobramoney case a different turn. In that case, the Indian Supreme Court declared its preparedness to exercise judicial review of executive or legislative acts to ensure that the Directive Principles are taken into account in government, programmes and policies. The decision in the Soobramoney case should be compared with the decision in B & Ors v Minister of Correctional Services 1997 (6) BCLR 798 (c) also cited as Van Biljon and Others v Minister of Correctional Services and Others 1997 (4) SA 441 (c). In that case, HIV positive prisoners claimed that they had a right to receive certain anti-retroviral medications at State expense. Such medications were provided to non-paying patients at provincial hospitals outside prison only under very limited circumstances. The court ordered the Department of Correctional Services to provide the necessary anti-retroviral treatment as the Department was unable to prove that it did not have the necessary funds and that the Department’s doctor had prescribed the anti-retroviral drugs.

The law as it is in Nigeria is still that the provision of health is not a right but a social objective. There is no amount of judicial activism that can alter the provisions of the Constitution. By virtue of section 4(1) 1999 Constitution of the Federal Republic of Nigeria legislative powers in Nigeria are vested in the National Assembly of the Federation which consists of the Senate and the House of Representatives. At best,
judicial decisions can assist for the purpose of the content of an amended version of a law.

From the foregoing, it recommended that in its administration, the right to health in Nigeria must include the right to organs for transplantation at the expense of the government and the administration of drugs and general treatment of persons who donate organs and patients into whom organs have been transplanted should be a constitutional right enforceable by a person with *locus standi*. It might take the dimension of litigation.

This has its nuisance value as well because while such litigation may eventually have effect on social rights and enjoyment of the citizens, a proliferation may also distract the government in other areas of national endeavour. Gloppen and Roseman have cautioned that it is prone to abuses and may result in the ‘epidemic of litigation’. This view is deeply faulted in that one of the potent ways of asserting rights is through litigation, the effect of which would determine the rights of parties.

The *Constitution of the Republic of South Africa*, 1996 is one of the few Constitutions in the world where socio-economic rights are justiciable in one document together with civil and political rights. These rights are contained in chapter 2 of that document and titled ‘Bill of Rights’. Some of the rights in the constitution are fully protected while access is protected in respect of others. With reference to the latter, section 26(2) provides: ‘The state must take reasonable legislative and other measures; within its available resources, to achieve the progressive realisation of this right’.

Section 27(1) of the Constitution provides that everyone has the right to: ‘Health care services including reproductive health care’. Section 27(2) provides a rider to that section by providing that; ‘The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights’. Section 27(3) guarantees further that no one may be refused emergency medical treatment.

By way of preliminary comments, it is not clear whether this provision applies to private hospitals and clinics and whether it will be unlawful for them to refuse emergency medical treatment where patients cannot afford to pay. This issue could be looked at
from two perspectives, one having more force than the other does. Firstly, that subsection may be enforced having in mind the beneficent role of the medical practitioner to the patient. Put in a different way, the ethics of the medical profession enjoin the medical practitioner to be beneficent. With this in mind, the practitioner may provide emergency medical treatment. The more potent of the two is the operation of the Constitution in section 8(2) which provides, ‘A provision of the Bill of Rights binds a natural or juristic person....’ This aspect is still unpredictable until the interpretation is subject to judicial opinion.

One of the most important and perhaps sensational cases on the right to access to health in South Africa is Soobramoney v Minister of Health, Kwa-Zulu Natal 1997 12 BCLR 1696 CC. In that case, Soobramoney, a 41-year old unemployed person was a diabetic who also suffered from ischemic heart disease as well as cerebro-vascular diseases which eventually resulted in stroke for him in 1996. In that same year, his kidneys failed. His condition was regarded as irreversible and as at the time of the litigation, he was in the final stages of renal failure. For the fact that he was impecunious, he stopped receiving dialysis from a private hospital for which reason he registered at the Addington State Hospital. The State Hospital denied him dialysis due to limited facilities available at that hospital.

Soobramoney made an urgent application to the High Court for an order directing Addington State Hospital to provide him with renal dialysis relying on sections 27 (3) and 11 of the Constitution. The refusal of that court to grant the application necessitated an appeal to the Constitutional Court.

In holding that section 27(3) of the Constitution did not apply to the application, the court asserted that the applicant’s condition was an ongoing state of affairs and not an emergency situation within the meaning of section 27(3). The court went further to hold that even if the situation of the applicant with chronic renal was to be regarded as an emergency; the state was not violating its obligation as its resources were scarce. The indubitable purport of this case is the discretion endowed unto the state in the issue of socio-economic right to health. The court was not prepared to enforce the provision of section 27(3) because of lean resources.

The case of Minister of Health v Treatment Action Campaign 2002 (5) SA 721 (CC), centred on issues relating to health. The case involved the South African government’s
policy of confining the provision of Nevirapine, an anti-retroviral drug that reduces the likelihood of HIV transmission from mother to child at birth to a number of research and training sites in the country. This approach was going to hinder access to the drug. The Constitutional Court decided that such restriction of the drug to the research sites only on the ground that the comprehensive package was not available at other public institutions was unreasonable in view of medical evidence that Nevirapine could still be effective even if administered without the full package of breast-milk substitutes and support services. The court further ordered the government to make the drug available at other public hospitals and train counsellors in its administration.

The starting point on the enforcement of economic, social and cultural rights is a brief discussion of the Bangalore Conference. The Conference, held in Bangalore, India, from 23-25 October 1995 was convened by the International Commission of Jurists, on economic, social and cultural rights and the role of lawyers in conjunction with the commission’s triennial meeting. See E/CN:4/1996/NGO/15. One of the issues considered at that conference was the expenditure involved in the attainment of economic, social and cultural rights. At that conference, some of the reasons why jurists have been reluctant in judicial review in the area of economic social and cultural rights of legally enforceable kind were discussed. The idea that social rights are non-actionable has been described as purely ideological and not scientific, as they stand out as authentic and genuine fundamental rights that are actionable, demandable and they require serious and responsible observance. For this reason, it has been said that they should be demanded as rights and not as gestures of charity administrable by the government discretionarily.

The Constitution of a Federal Republic of Nigeria 1999 does not recognise the right to health as justiciable. Both countries are signatories to international and regional human rights instruments that guarantee the right to health. The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 is one of them. This covenant was adopted and opened for signature, ratification and accession by the UN General Assembly Resolution 2200 A (xxi) of 16 December 1966 and it entered into force on 3 January 1976. Others include the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW) adopted through GA Res 54/180 UN GA OR 34th Session Supp 46 Un Doc A/34/46 1980 and the
Lofty as this preamble is, state parties pay lip service to the enforcement of that treaty and the sincerity in adopting them for administration is regrettably circumspect. The decision of the African Commission on Human and Peoples’ Rights in SERAC & CESR v Nigeria is apposite in this respect. That decision reinforced the view that internationally accepted ideas of the various obligations under Economic, Social and Cultural Rights involved four layers. These are duties to respect, protect, promote and to fulfil. The last of the duties was important to states as it would make them to provide the basis needs of the citizens.

One of the basic needs of citizen is good health. If the right to health is made enforceable and moved from chapter II of the Constitution of the Federal Republic of Nigeria 1999 to chapter IV, the effect would be that there will be access to health as a right enforceable under the Constitutions. One strung of this view is that in matters of transplantation of organs, the state would bear the cost at pre-treatment, treatment (surgery) and post-treatment stages.

What is being recommended in this respect is a shift in the constitutional paradigm of non-enforceability of the right to the access to health.

What is recommended is an amendment of section 6(6)(c) of the Constitution which makes the provision of chapter II, with reference to the access to health, non-justiciable. Another way to this matter is the removal of section 17(3)(d) of the Constitution from chapter II to chapter IV of the Constitution. One of the effects of this is a municipal recognition of African Commission on Human and Peoples’ Rights, ACHPR/Res. 141 (xxxxiii) 08: Resolution on Access to Health and Needed Medicines in Africa. If this is done, it will enhance the value of health, increase the confidence in government and its
policies and prolong the lives of patients who may be in need of transplantation of organs.

All that this entails is an amendment of the Constitution of the Federal Republic of Nigeria 1999 by the operation of section 9(1) of that Constitution. That section provides as follows; ‘The National Assembly may, subject to the provisions of this section, alter any of the provisions of this Constitution’. The process of altering the Constitution under this sub-section is less technical than the process under section 9(2) which refers to section 8 of that Constitution, on state creation, and provides that an amendment for that purpose shall only be passed if it is supported by the votes of not less than two-thirds majority of all the members of that House and approved by resolution of the Houses of assembly of not less than two-thirds of all the states With this, the right to health will become justiciable under the Constitution (as amended).

If this becomes a reality, there would be the imperative of monitoring the actions of the government in order to determine the level of implementation of that right, identify existing and potential barriers to the enforcement of this right and discern areas of existing and future violation of the right. Admittedly, it may be difficult for the government to provide an unbiased assessment of itself in this respect. What will suffice is a coalition of non-governmental organisations whose focus is on health. The reports of the efforts of these organisations will direct the government in the following ways:

a. providing a compass for the development of health and health facilities.

b. identifying the effects of health policies and regulations and possible needs for amendment.

c. assisting in formulating policies and regulations and determine the progress made by the operation of extant policies and regulations.

d. determining the cost of intricate health matters like procurement of organs and their transplantation.

This can only be done where the government has the political will and commitment to promote the right to health of the citizens.

After this comes the issue of property in the cadaver. This aspect was discussed earlier in this lecture. This is an important aspect of this work because morally, the sale of organs is condemnable.
In view of the operation of the ‘opt in’ regime, cadaveric donations are rare and relations are not too enthusiastic about donating the bodies of their relations after their death.

The report of the survey at Balogun Market, Lagos, Nigeria, seems to capture the mood of the generality of Nigerians on this matter. The situation might in fact be more negatively tilted in areas of the country with low literacy level. These samples are shown in the graphic form in Table B shown earlier. All the samples of our interview expressed the fact that their bodies belonged to them and that their relations will take the property in them after their demise and that the state cannot claim property in their bodies to the exclusion of their relations.

10.9 With these scenario, how then can organs be procured? The right to intern a relative rests in the living relations. As way of procuring bodies, the state responsibility approach is recommended. By this approach, due to the failure of the voluntary approach in procuring bodies and therefore organs, it is morally and practically necessary for the society to overcome this failure by making the cadaver the responsibility of the state to determine its disposition. In coming to this conclusion, the author’s premise is that after death, the body decays and is dispossessed of all the rights of a living person. If the cadaver is used as described it moves from an object with no intrinsic value destined only for disposal to a vital source which becomes quite new in human experience. This approach is the ‘opt out’ regime. Two strong impediments to this approach are the cultural and religious beliefs of the people.

In order to overcome this, the starting point would be to educate people on the vanity in a cadaver but usefulness in it if it is donated before death or allowed to be possessed by the government. The attention of the people, in this respect, must be directed to therapeutic uses of procured organs and the virtue in altruistic donation of organs. In other words, there is the need for public enlightenment on how useful individuals may be to fellow human beings even in death.

What is being recommended in this context is not a complete adoption of the ‘opt out’ approach *ad baculum* by the government. The approach that is being suggested is a process of mass education on donation of bodies before death, acquisition of bodies by
the government after which the process will take a statutory dimension. This will take the shape of a law, making bodies the property of the state after death.

Obviously, it cannot be all bodies that will be useful after death. For instance, ailing organs of dying and dead person cannot be useful for therapeutic purposes for which reason it may amount to a waste of time and resources to remove them. It would also be maleficent if such organs are transplanted into patients. In addition, persons who die due to the old age and collapse of their organs may not be useful for this purpose. The most useful are accident victims who are in an irreversible state with absent apnoeic reflex and are brain-dead. At all events, consent will be sought and obtained before acquiring the bodies.

In this connection, the recommendation on this point is that the Maastricht categories be adopted. These include the following cases;

a. dead on arrival
b. unsuccessful attempts at resuscitation
c. controlled withdrawal of life support without attempts at resuscitation
d. cardiac arrest after brain death.

In all these situations, it is still recommended that at least three medical practitioners certify death with such practitioners not having interest in the use of an organ removed from the body.

The second leg of this recommendation touches on persons who are condemned to death through constitutional procedures within the jurisdiction. In order to swell the vault of the organ bank and the doubtless positive quality life benefits for organ recipients, it is recommended that an Act be enacted to commute death sentenced to life jail if the convict consents to donate an organ. The jurisprudential underpinning of this is that death sentence removes the convict entirely from existence. Where a patient, who is not convicted for an offence does not succeed in procuring an organ to replace an ailing or failed organ, such a person would also be entirely removed from existence.

There is no justification for losing two persons when one, through the operation of the law, can consent to donate an organ which would be used to keep the recipient healthy and alive, and stay alive in the process. It is noted that recipients may not be willing to admit that they received the organ of a person condemned to death in order to stay alive. Both the recipient and donor are entitled to their respective rights to privacy. In
this respect, there is need for strong considerations for sparing the life of a criminal who would be ready to lose an organ for which reason another person may stay alive. The reason for donation of the organ by the convict may not be altruistic but at the same time, it will serve the purpose of preserving the life of another individual who may be otherwise useful to the society after the removal of an ailing organ and the transplantation of a healthy one into the body.

The Transplantation Association of Nigeria is there to ensure that transplantation is safe for professionals and patients and widely available using best practices. The mission statement of this association is to provide leadership and guidelines on ethical practices, facilitate development of clinical care and promote education.

From both the vision and the mission statement of the Association, it is clear that it does not serve the same objective as the Organ Donor Foundation, that is, procurement of organs. It is more concerned with the ethics of transplantation, care for patients and development of clinical care.

In the course of this research, we undertook a search into the portals of the Corporate Affairs Commission of Nigeria.

It was found that the association is not registered under the Companies and Allied Matters Act Cap C35 Laws of the Federation of Nigeria 2004. If this association intends to make a success of its lofty mission, it is imperative to register under the relevant laws. With this, it will be able to operate within the ambit of the law and it can rightfully assist both the government and the public in matters relating to transplantation of organs.

Another organisation in Nigeria with a similar motive is the Nigerian Association of Nephrology. As the name implies, it deals with matters relating to renal diseases. Just like the Transplantation Association of Nigeria, it was found from the portals of the Corporate Affairs Commission that this association is not registered under the relevant laws of Nigeria.

This notwithstanding, the Association at its Annual General Meeting held in Lagos on 6 February 2013 noted as one of the items in its communiqué that the National Health Insurance Scheme of Nigeria does not cover for renal replacement therapy for which
reason it called for legislative amendments in the laws to cover this aspect of medical practice.

This recommendation, if adopted, has the potentiality of increasing the population of organs in the organ bank, prolong the lives of recipients and assist the government in the bid to ensure the access to health as a right within the legal system.

10.10 The donation of an organ by a donor is an autonomous issue. By this, it is meant that the donor possesses the freewill to decide and make a choice from a plethora of options. He/she is responsible for the option he/she takes. For this reason and more, it is necessary to consider giving some pecuniary advantage to unrelated donors because there is usually a burden or benefit for any action taken.

In view of the above, it is recommended that there should be a legalised system whereupon donors will be compensated for their forbearances, particularly the altruism in donating an organ to the recipient in order that he/she may live and be useful to himself/herself and the society. In the final analysis, this recommendation if adopted will ease the shortage of organs and allow recipients to pursue their lives more meaningfully.

10.11 In addition to all the above recommendations, it is suggested that the Federal Government of Nigeria establish the National Board on Transplantation of Organs. (NBTO). This Board will be endowed with powers on all aspects of transplantation of organs. It is recommended that the Board be created under an Act known as the National Human Organ Transplantation Act. This Act will, among other things determine the requisite personnel for transplantation surgeries, assist in research for the definition of brain-death, provide training and continuing education for staff in the specialised boards as well as financial incentives for this highly technical and intricate aspect of medical practice.

Other duties of the Board would include the setting up of Transplant Centres on regional basis in Nigeria respectively as well mass education of the public on the virtues of donating organs.

The legislation in reference would form the basis for the implementation of a national strategy and policy on transplantation of human organs. It will also formulate operation
procedure, determine procurement strategies for organs as well as distribution and be in charge of post-surgical treatment for both the donors and the recipients.

11.0 Conclusion
There is yet no legal framework for the regime of transplantation in Nigeria. Mr Vice Chancellor, my distinguished audience, in order to save the lives of many Nigerians who need transplantation of organs, there is the urgent need to look *Towards a Regimen for the Transplantation of Human organs in Nigeria.*

Epilogue
It is imperative to acknowledge the contributions of various persons and establishments to my present status. Doing this was quite difficult because I knew I would underestimate the quantum of the contributions of some of my benefactors and in some cases, I will forget, as is wont to human tendencies.

I take full responsibility for my omissions in this respect and I tender an unreserved apology just if any person in this gathering feels he or she has not been well acknowledged.

One morning, in 1979, I presented the form for the Direct Short Service Commission of the Nigerian Defence Academy to a gentleman who refused to sign the parent/guardian portion. He did the same for the Police Cadet Admission form.

Two weeks thereafter, this gentleman and his wife woke me up on a warm Saturday morning with a warning as follows;

“Ayotunde, if you don’t read Law, we shall not pay your school fees”.

All the dreams of using physics and mathematics which were my best subjects were threshed, burnt and consigned into oblivion.

Today, I thank this couple for their firmness on me otherwise, I probably would not be presenting this lecture today. The couple in reference were my parents, Mr. Johnson Adedayo Sokefun, my father and mentor and Mrs. Esther Alake Subusola Sokefun, a woman of pastoral pedigree having been born into a family of clergymen at Pultney Street in Freetown, Sierra Leone. Both of them are deceased but their memories are evergreen.

My brothers and sisters Adekunle, Olufemi, Babasola, Johnson, Yetunde and
Anthonia (deceased) also contributed in the growing up process. They know their contributions and I am grateful to them. By this same token, I am grateful to Mr and Pastor (Mrs.) Jimi and Deborah Adeleye. Two specific contributions of this couple deserve mention. First, in 1985, Uncle Jimi gave me a brand new Peugeot 504 with weekly allowances for fuel and maintenance. You can imagine how I felt having just graduated from the Nigerian Law school. The second and lasting contribution is that Uncle Jimi and my Uncle, Chief Josiah Adebowale forced me out of “enjoyment” to build a house in 1994. I shall forever be grateful to the two of them for all these and more.

My colleagues at the church, particularly at the Hoares Memorial Methodist Church, Yaba, All Saints Church (Worldwide), Ijebu-Ode as well as my colleagues at the chambers, Prayer Warriors Group and Beulah Ministries have been wonderful. The grace of God shall continue to abide with them and their kin.

Out of my many classmates at the institutions I attended, two stand out because of our closeness. These are Olufunsho Olagoke and Canon Babatunde Oduwole, the current principal of our *alma mater*, the CMS Grammar School Lagos. These two boys share with me the memory of many events that I dare not mention here. I am grateful to them for contributing to an exciting adolescence.

I am particularly grateful to my wife and children for their unflinching support up to this point in my career. They have contributed immensely to my writing disposition. By the same token, I must express my gratitude to Dr. Olu Onagoruwa SAN, the former Attorney General of the Federation Republic of Nigeria and Minister of Justice. Without a godfather or godmother, just the mere recommendation by his late son, Oluwatoyin Onagoruwa, I was appointed the Special Assistant to the Attorney General and Minister of Justice 1993. This appointment thrusted me into memorable events. For instance, I was in the first list of six lawyers that represented Nigeria at the International Court, Hague. This gave me the unique opportunity of working with the best brains in Public International Law like Professors Ian Brownlie, Crawford, Ayo Ajomo, Itse Sagay and Rosalyn Higgins. I also participated at the foundation of the Constitutional Conference of 1994. These events changed my academic perspective of politics and governance.
My formative years as an academic were at the Ahmadu Bello University, Zaria and Olabisi Onabanjo University, Ago-Iwoye.

I blossomed and flourished at Olabisi Onabanjo University, Ago-Iwoye. As you may imagine; I was like the tendril of the palm tree.

I am grateful to that institution for allowing me to express myself up to the zenith of academic achievements. The Master of Law programme and the giant lecture theatre remain two great legacies which God gave me the grace to leave in that institution.

Referring to Olabisi Onabanjo University, I must mention the contributions of two persons to my success and achievements. First is Professor Olatunji Yinusa Oyeneye, the 3rd Vice Chancellor of that University and so far the only Vice Chancellor in Nigeria that was elected by members of the senate and congregation. Twice he appointed me as the Head of Department of Public Law and Jurisprudence.

He encouraged me to write profusely after having been promoted to the rank of Senior Lecturer in 1996. This served as a springboard to further promotion: Professor Olatunji Yinusa Oyeneye is a distinguished academic with many laurels.

The other person is Professor Afolabi Soyode, the fifth Vice Chancellor of the University. Today, he stands as my mentor, father and confidant. During his administration, I was appointed an Acting Dean, and later a Dean after attaining the rank of Professor of Law. Professor Afolabi Soyode is a polished academic who governed Olabisi Onabanjo University without personal prejudice.

To these two people goes my unquantifiable appreciation.

We were three Professors that left Olabisi Onabanjo University for the National Open University of Nigeria. Professor Victor Oluwole Adedipe came first and showed the light to my late brother and friend, Professor Afolabi Adebanjo. The latter showed me the light. I am grateful to brother Victor for his steadfastness and to the memory of Professor Adebanjo for teaching me how to be finicky and firm.

It is imperative to express my appreciation to the management, staff and my colleagues in this university. I must say that the management of the National Open University Nigeria has given me a nearly unbridled access to international exposure on open and distance learning. My gratitude for this can never be enough. I am deeply grateful to my colleagues in the School of Law. I share the same dream with them. I am grateful to them for their cooperation in moving the School forward.
My appointment to this university was through Professor Olugbemiro Jegede, a well rounded exponent and advocate of Open and Distance Learning. I am grateful to him for giving me the opportunity to see learning instruction from the other side of the prism. In spite of the nearly overvaulting challenges that Law has in Open and Distance Learning, I have no regret in being a Law academic in this institution.

I am extremely grateful to Mr. Ernest Ugbejeh, Miss Adetoun Oyedele, Dr. Olugbenga Ojo, Dr. (Mrs) Adejoke Uthman, Dr Tosin Awolalu, Professor Vincent Ogunlela and Professor Israel Adu for their constant encouragement in this endeavour. Their request for a constant updating on this lecture provided the fillip for its timely completion.

I am immensely grateful to the Vice Chancellor, Professor Vincent Ado Tenebe. This gentleman is a listener and an administrator with passion and reward for hardwork and commitment . Without lobbying, he reappointed me as the Dean of Law in November, 2013 and has given me all the support I need to overcome the many challenges in the administration of the School.

Finally, I thank God, my Alpha and Omega for His love to me and for being my God at all times.

Mr. Vice Chancellor, distinguished audience, permit me to rest my case.
Thank you for giving me your warm attention.

Professor Justus A. Sokefun
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