# ADVANCING THE LAW ON MEDICAL NEGLIGENCE IN NIGERIA: THE NEED TO ADOPT INTERNATIONAL BEST PRACTICES.

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**DECEMBER, 2025**

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**A LONG EASSY WRITTEN AND SUBMITTED TO THE FACULTY OF LAW, UNIVERSITY OF BENIN IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THR AWARD OF THE DEGREE OF BACHELOR OF LAWS (LL. B) OF THE UNIVERSITY OF BENIN, BENIN CITY.**

**DECEMBER, 2026**

## CERTIFICATION

I, Elijah Aisosa ERHUNMWUNSEE, with Matriculation Number LAW2002863, hereby declare that this work is the product of my own research efforts; undertaken under the supervision of Dr. J. A Aimienrovbiye and has not been presented elsewhere for the award of a degree or certificate. All sources have been duly distinguished and appropriated acknowledged.

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APPROVAL

This is to certify that the research work for this dissertation and the subsequent preparation of this dissertation by Elijah Aisosa ERHUNMWUNSEE (LAW2002863) were carried out under my supervision.

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## DEDICATION

This project is dedicated to God almighty for his infinite mercies and love upon my life, to my entire family for their unending love and support. Also to the Law, its teachings and the pursuit of knowledge.

## ACKNOWLEDGEMENT

I thank God almighty for the successful completion of this work, for his unending grace and mercies shown to me. I am grateful for the wonderful people he brought my way through out my LLB journey, it was by his strength and the support of those he surrounded me with I was able to successfully complete this journey. By his strength and divine favour I will be able to move on to my next phase of life.

I express my profound and heartfelt appreciation to my project supervisor, Dr. J. A. Aimienrovbiye, for her exceptional guidance, patience, mentorship and scholarly insight. Her encouragement, understanding and unwavering support played a vital role in shaping this work, and without her dedication, this project would not have come to recognition. I am deeply grateful for the opportunity to learn under her supervision.

My sincere appreciation goes to my wonderful parents. I remember with deep love and respect my late father, Mr. Pius Erhunmwunsee, whom I lost to the cold hands of death during the course of completing this project. His advice, prayers and unending support throughout my life laid the foundation for this achievement. Without him, I would not be writing this acknowledgement today. May his soul continue to rest in perfect peace. I am equally grateful to my mother, Mrs. Dora Erhunmwunsee, whose sacrifices, prayers and constant support sustained me. Thank you for keeping me on the path of the Lord, for instilling good morals in me, and for being my gist partner and pillar of strength.

I sincerely appreciate my siblings: Pius, for always coming through for me when I needed help; Lawrence, for constantly encouraging me not to give up, reminding me to take it

easy, and for always putting a bright and radiant smile on my face, as well as being my personal ATM; and my sister Mary, for always being there for me, for being my second mother, treating me like a son, and for being my gist and gossip partner and second ATM.

My appreciation also goes to my cousin Sarah, for always perturbing me in love, being my movie plug and reliable source of information. I am grateful to my aunties: Aunty Eunice, for her unending support, help and advice, may God continue to bless you; Aunty Lucy, for her constant encouragement, advice and for always checking up on me, may God bless you; and Aunty Philo, for her help and support.

I acknowledge my long-lost friend Hillary for the help rendered towards this work, my day-one Ololade for being a true friend, and Big Mof, my two-time roommate, for patiently explaining difficult courses to me. I appreciate Alex, Okdizzy, Obano, Kewe and Michael for being friends throughout my LLB journey. My thanks also go to my first-ever roommate, Dr. Philip, for being a cool and understanding roommate.

I am grateful to Deborah for always being there for me and for the countless snacks and meals, and to Rachael for her kindness and care, always coming through for me when there seemed to be no hope for food. I also appreciate Big D, Osayi, Nadia, Koko, Zeb, Edos, Fome and Rukky for being part of my LLB journey.

My sincere gratitude goes to the members of Legal Lions for giving me the opportunity to prove myself as a coach, even when some people doubted me. I also thank the Luminaries, Class of 2025, for being wonderful course mates. I appreciate my DRT

family for improving my acting skills and for being my second family and a safe place away from the harsh realities of UNIBEN.

I extend my appreciation to all my lecturers in the Faculty of Law for imparting knowledge and discipline in me. The teachings and guidance I received have greatly shaped my academic and personal development.

Last but not the least, I want to thank me, I want to thank me for believing in me, I want to thank me for doing all this hard work, I want thank me for having no days off, I want to thank me for never quitting, I want to thank me for always being a giver and trying to give more than I receive, I want to thank me for trying doing more right than wrong, I want to thank me for just being me at all times.

To everyone who contributed in one way or another to the success of this work, I am sincerely grateful.

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## TABLE OF ABBREVIATIONS

| | |
|---|---|
| A.C | Appeal Cases |
| CA | Court of Appeal |
| FCCPA | Federal Competition and Consumer Protection Act |
| FWLR | Federal Weekly Law Reports |
| HEFAMAA | Health Facility Monitoring and Accreditation Agency |
| LFN | Laws of Federation of Nigeria |
| MDCN | Dental Council of Nigeria |
| MDPDT | Medical and Dental Practitioners Disciplinary Tribunal |
| NHIA | National Health Insurance Authority |
| NMLR | Nigerian Monthly Law Reports |
| NWLR | Nigerian Weekly Law Reports |
| Q.B | Queen Bench |
| S.C | Supreme Court |
| UK | United Kingdom |
| UKSC | United Kingdom Supreme Court |
| W.L.R | Western Law Reports |

***Abstract***

*This study examines medical negligence in Nigeria, focusing on the prevailing legal standards, the allocation of the burden of proof, and mechanisms for patient protection. Anchored in doctrinal legal methodology, the research draws upon statutory instruments such as the National Health Act 2014, the Medical and Dental Practitioners Act, and constitutional provisions that underscore the right to health and life. Additionally, the role of regulatory institutions—especially the Medical and Dental Council of Nigeria (MDCN)—is assessed in maintaining professional standards and enforcing disciplinary frameworks. The analysis then unpacks the foundational tort elements of medical negligence as recognized by Nigerian jurisprudence and mirrored in comparative doctrine—namely, duty of care, breach of that duty, causation, and resultant damages. The inquiry further explores nuanced exceptions, particularly the doctrine of res ipsa loquitur, which can shift the evidential weight onto the defendant where negligence is self-evident. Central to the project is an examination of the burden of proof. The patient claimant bears the primary responsibility to establish negligence on the balance of probabilities as per Section 134 of the Evidence Act (2011). The study highlights key patient protection avenues—civil claims for damages, criminal liability for gross negligence, regulatory sanctions via the MDCN, and the enforcement of informed consent and patient rights under relevant statutes.In conclusion, while Nigeria's legal framework articulates clear substantive standards, systemic barriers—including procedural complexity, high litigation costs, scarcity of expert testimony, and cultural reticence—severely impede access to justice. This project ultimately recommends procedural reforms, enhanced judicial capacity, and institutional innovation to bolster the adjudication of medical negligence claims and better protect patient rights.*

# CHAPTER ONE
# GENERAL INTRODUCTION

## 1.1 BACKGROUND OF STUDY

Professional negligence in the medical field has been on the rise and must be addressed through the legal system to better safeguard patients. It is also essential to hold medical practitioners accountable, as instances of negligence have prematurely cost many patients their lives. Such accountability would help restore public confidence in the medical profession. At the same time, patients need protection from practitioners who have shifted their focus from saving lives to prioritizing financial gain. In many advanced countries, legislative measures have been introduced to ensure that negligent medical practitioners are held liable and required to compensate affected patients or, in cases where negligence results in death, their families.

Healthcare delivery is fundamental to safeguarding life and dignity in every society. In Nigeria, the medical field commands much admiration due to its pivotal role in securing the health of the populace. The increase in medical negligence and malpractice, however, has become exceedingly problematic, far contributing to patient injury, permanent disability, or death. This has raised immediate legal, ethical, and policy questions over the duty of medical professionals, the adequacy of the legal systems in Nigeria, and the protection of the rights of patients.

The right to life under Section 33[1] also imposes a duty on the State to safeguard citizens against unlawful threats to life, including those resulting from medical error. Similarly, the State is obligated under Section 17(3)(d) of the Constitution to provide proper medical facilities. To discharge this obligation, the Medical and Dental Practitioners Act and the National Health Act 2014[2] came into force with the objective of regulating the practice of medicine and protecting patients' rights to quality care, informed consent, and emergency care. However, despite these legislative safeguards, misdiagnosis, prescription errors, post-operative complications, and non-consensual treatment are endemic in Nigerian healthcare Opara, 2025.

Medical negligence in Nigeria represent more than a lack of adequate care but an interplay of ethical issues, laws, health policy, and rights violations. Though there are continued advances, Nigeria's health system continues to suffer from poorly equipped facilities, ineffective regulation, and repeated professional conduct failures that actually imperil patients. Here, medical negligence has been described as a failure of a health practitioner to adhere to an acceptable standard of care that results in injury or death. On the other hand, malpractice can constitute negligence but also entails a willful misconduct, breach of ethical standards, or a blanket failure of a system.

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[1] The Constitution of the Federal Republic of Nigeria 1999

[2] Medical and Dental Practitioners Act and the National Health Act 2014

A fundamental legislation comprises the Medical and Dental Practitioners Act[3], outlining the disciplinary procedures handled by the Medical and Dental Practitioners Investigation Panel (MDPIP) and the Disciplinary Tribunal.[4]

Also, the Code of Medical Ethics[5] provides guidelines on professional conduct. Laws and guidelines are, however, only part of the equation implementation and enforcing issues and inaccessible nature constitute grave challenges.

Instances exist that exemplify the occurrence of medical negligence in Nigeria. The case of *Medical and Dental Practitioners Disciplinary Tribunal v. Dr. John Emewulu Nicholas Okonkwo*[6] serves as a pivotal example. In this particular case, Dr. Okonkwo provided medical treatment to Mrs. Martha Okorie, a Jehovah's Witness who declined a blood transfusion on religious grounds. The tribunal adjudged him guilty of infamous conduct for failing to either arrange for the patient's referral to another facility or terminate the medical contract, despite having documented the patient's refusal. The Supreme Court upheld certain aspects of the tribunal's findings, elucidating matters related to informed consent, the ethical obligations of professionals, and the delineation of practitioners' responsibilities during medical emergencies as opposed to patient autonomy[7].

Another notable case is *Ojo v Gharoro*[8], where Miss Felicia Osagiede Ojo alleged that a surgical needle had been left broken in her abdomen during surgery and therefore charged negligence. She appealed at the Supreme Court claiming damages. But the Court rejected her appeal and ruled that an abnormality (broken needle) per se could not automatically connote negligence; she should produce expert evidence to prove breach of standard of care, causation and all the ingredients of negligence[9].

The recent State of *Lagos v Dr. Ejike Ferdinand Orji*[10] reveals the imposition of criminal responsibility with regard to medical negligence. In this specific context, the professional was convicted of negligence, recklessness, and causing injury leading to a deformity of a passenger's leg (Master Somi Ezi-ashi). These proceedings used the medical records secured through subpoenas from Investigation Panel extensively and testimonies of specialist witnesses, namely of orthopedic surgeons. What's peculiar and important with regard to this particular case lies in the fact that it reveals the imposition of criminal responsibility beyond disciplinary or civil charges.[11]

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[3] Medical and Dental Practitioners Act (Cap. M8) of the Laws of the Federation of Nigeria

[4] <https://lawcarenigeria.com/medical-and-dental-practitioners-act-1988/?utm> accessed 23rd September 2025

[5] Medical Ethics (2004)

[6] Medical and Dental Practitioners Disciplinary Tribunal v. Dr. John Emewulu Nicholas Okonkwo (2001)

[7] ,https://www.globalhealthrights.org/medical-and-dental-practitioners-disciplinary-tribunal-v-okonkwo/?utm>_accessed 23rd September 2025

[8] *Ojo v Gharoro* (2006) 10 NWLR (Pt. 987) 173.

[9] <https://nigerianlawforum.com/case-law/ojo-v-gharoro-2006/?utm>_ accessed 23rd September 2025

[10] *State of Lagos v Dr. Ejike Ferdinand Orji* (2023) (Unreported Decision In Suit LD/8963/2019

[11] <https://nannews.ng/2023/04/19/medical-negligence-lagos-commendable-for-orjis-conviction-odefa-wachuku/?utm>_accessed 23rd September 2025

Despite such cases, there are exceptions. Most instances are never sent to trial or tribunal due to unawareness, economic inability, or procedural complications. Most prospective victims remain unaware of their rights or where to file complaints. Practitioners and hospitals can also deploy defenses of standard practice or resource deficiency. Additionally, Registry of cases, pace of adjudication, and uniformity of sanctions are inconsistent.

The importance of investigating this domain is considerable: first, for law students and prospective attorneys, comprehending the legal treatment of medical negligence is integral to tort law, administrative law, constitutional rights (such as the right to life and bodily autonomy), and human rights. Second, from a public policy perspective: grasping effective enforcement strategies and identifying failures aids health regulatory organizations (such as MDCN), the judiciary, the legislature, and civil society in developing improved mechanisms. Third, concerning societal welfare: when patients experience harm due to negligent medical practices, the repercussions extend beyond physical and emotional injuries to include financial consequences, erosion of trust in the healthcare system, and implications for public health. As a result of Nigeria's demography, disease health burden, inability of achieving equitable access to health facilities, and infrastructural shortcomings, medical negligence has major repercussions.

Towards this end, this research therefore aims at defining the existing law, exploring relevant case law, establishing mechanisms of enforcing that exist, examining issues faced, and providing recommendations that could foster patient protection while ensuring fairness to health practitioners.

## 1.2 HISTORY AND ORIGIN OF MEDICAL NEGLIGENCE IN NIGERIA

The understanding of medical negligence in the Nigerian case best stems from the analysis of its common law origins that were internalized because of British colonial influence. With Nigeria being a country once ruled by Britain, it incorporated English principles of common law as a direct outcome of the Reception Statutes of 1863 and later legislation while a colony. Hence, the first legal principles governing professional conduct, including medical negligence, basically entered the Nigerian system of laws.[12] This integration provided the foundation upon which Nigerian legal principles for medical liability have been developed; yet, assimilation according to local conditions was sluggish and sometimes uneven.

Medical negligence, as an identifiable unlawful transgression, derives from the general law of torts, specifically the tort of negligence as established in the seminal case *Donoghue v. Stevenson.*[13] The so-called "neighbor principle" defined by Lord Atkin as the notion of duty of care has become an integral tool in delineating liability in fields other than that of medical practice. This notion was then transplanted into medical practice

[12] C.O Okonkwo, 'The Reception of English Law in Nigeria' (Paper presented at NALT Conference, 1980).
[13] *Donoghue v. Stevenson*, (1932) A.C. 562 (H.L.).

with the decision in the case of *Bolam v. Friern Hospital Management Committee,*[14] and it established there the so-called "Bolam test": a medical practitioner is not negligent if his actions are reasonable and are supported by a responsible body of medical opinion. Nigerian courts, as bearers of the principles of received English law, have equally adopted the said doctrines in deciding medical malpractice cases.[15]

The history of medical negligence in Nigeria is intertwined with the evolution of systems for the delivery of health care. In the pre-colonial era, medical practice was largely based on traditional and community-oriented care with customary standards rather than enacted liability rules. The introduction of Western medical practice across the colonial period reversed this dynamics. Institutions such as the Sacred Heart on Abeokuta (1895) Nigeria's first private hospital and later government-funded hospitals brought about formal interactions between patients and medical practitioners.[16] The formalization brought with it the potential for conflict and, as a corollary, the need for the rule of law as a means of ensuring practitioner accountability.

Following independence in 1960, Nigerian law began to grapple with the complexities of medical negligence within a modernizing healthcare system. For much of the early post-independence period, litigation was sparse, partly due to cultural hesitance to challenge authority figures, including doctors, and partly due to limited public awareness of legal rights. However, by the 1970s and 1980s, judicial recognition of professional responsibility became more visible. Landmark cases such as *Dr. Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*[17] and *Esangbedo v. State*[18] reinforced the principles of competence, patient rights, and accountability.

Although Okonkwo's case primarily dealt with medical ethics and disciplinary procedures, it signaled the Supreme Court's openness to scrutinizing the balance between professional autonomy and patient protection. Over the last couple of decades, the field of medical negligence in Nigeria has expanded enormously. Patient awareness, coupled with crumbling health infrastructure and an enhancement in malpractice incidents, has led to escalation in legal proceedings. Nigerian judicial institutions, even while yet extensively dependent upon English case law, have increasingly incorporated ideas of medical negligence better accommodating Nigeria's socio-economic settings. For example, while the "Bolam test" still commands much influence, there is growing

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[14] [1957] 1 W.L.R. 582 (Q.B.).
[15] A.O Jegede, 'Medical Negligence and Professional Liability in Nigeria' *NALT Annual Conference Proceedings* (1991).
[16] C.C.Obi, 'Historical Development of Medical Jurisprudence in Nigeria' *NALT Journal of Contemporary Law* (2005).
[17] (1999) 9 NWLR (Pt. 617) 1 (S.C.).
[18] (1989) 4 NWLR (Pt. 113) 57 (C.A.).

awareness among academics and judges concerning its deficiencies amidst a medical system defined by resource scarcity, staffing deficiencies, and infrastructural decay.[19]

Moreover, scholarly discourse, and specifically that encouraged and facilitated by the Nigerian Association of Law Teachers (NALT), has played a key role in shaping this evolution. NALT conferences have again and again highlighted the failure of prevailing tort principles to adequately address the problem of malpractice so prevalent in Nigeria's distinctive health care system.[20] Scholars argue that, as opposed to advanced jurisdictions where negligence actions have served as both compensatory and regulatory tools, Nigerian systemic failings all too often render effective sanctioning prohibitive. There is a running debate as to the sufficiency of an exclusively common-law system, or even a possible necessity for legislative intervention such as the enactment of a dedicated Medical Negligence Act to strengthen the protection of patients.

**Significant Tests**

The development of medical negligence in Nigeria presents an interrelated dynamic between established English principles of law, judicial adaptations, and intellectual commentary. Even while Nigerian courts have been successful in applying doctrines such as the duty of care and the Bolam test, challenges remain in applying it in the very different Nigerian healthcare context. The failure for extensive reform through statute means that exclusive case law reliance has brought about significant gaps, particularly in ensuring fair access to redress for poor patients. Moreover, the continuing significance of customary and traditional healing raises questions of the necessity of an extension of principles of negligence over practitioners using non-Western methods. In short, the development and inception of medical negligence in Nigeria reflect both continuity with English common law and incremental, albeit partial, indigenization. The jurisprudence continues to develop, as a result of judicial activism, intellectual discourse, and the socio-economic conditions of Nigeria's weak health system.[21]

## 1.3 MEANING OF MEDICAL NEGLIGENCE

In Nigerian law, medical negligence can be described as the violation of duty of care imposed upon a medical provider in the treatment of a patient, leading to harm, impairment, or death. The cause traces its foundation in the tort of negligence as evolved under English common law and has been incorporated in Nigerian law through reception statutes and case precedents.

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[19] A Oluwatayo, 'Challenges of Tort Law in Regulating Medical Practice in Nigeria' *NALT Conference Proceedings* (2017).

[20] O Adeoye, 'Patient Rights and Medical Negligence in Nigeria: A Critical Review' *NALT Annual Conference Papers* (2019).

[21] B. Eze, 'Towards a Statutory Framework for Medical Negligence in Nigeria' *NALT Journal of Health Law* (2021).

The original case for negligence is *Donoghue v. Stevenson,*[22]wherein Lord Atkin established the "neighbour principle." The said principle formed the foundation for duty of care in professional relationships, e.g., doctor/patient relationship. The courts in Nigeria have adopted this principle in medical negligence cases.

In *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*,[23] the Supreme Court underlined medical practitioners' obligation to provide patients with reasonable and skilled standard of care in medical practice. Uwaifo, J.S.C., noted that although there was not an obligation on a physician to ensure cure, there was an obligation to provide reasonable care and exercize professional skill.

In an analogous case, *Esso West Africa Inc. v. Oyegbola*,[24] the court recognized that negligence arises whenever a duty of care obliging individual fails to meet the standard of a reasonable professional in similar circumstances. As this case does not apply strictly to medical cases, it strengthened the general duty of care precedent in play in tort law, including in medical situations as well.

Medical negligence, thus, would comprise actions such as:

1.Incorrect diagnosis,

2.Surgical errors,

3.Inability to provide informed consent,

4.Medication errors,

5.Abandoning post-operative care.

To establish liability, the claimant is required to demonstrate the three essential components of negligence:

Duty of Care – legal obligation of the doctor to the patient. Breach of Duty – failure to reach the standard of reasonable medical skill and judgment.

Causation and Damage – evidence that violation directly resulted in damage or injury *Ibrahim v. Abdullahi*.[25]

In Nigeria, medical negligence can both be asserted as a tort and under professional disciplinary measures instituted by the Medical and Dental Practitioners Disciplinary Tribunal (MDPDT). The courts have, over time, been firm in holding as follows: Though medicine is not an exact science, medical practice has an obligation for perceived standard of care in medical practice[26].

Consequently, medical negligence within the Nigerian context may be clearly articulated as:

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[22] (1932) A.C. 562.

[23] (1999) 9 NWLR (Pt. 618) 1.

[24] (1969) 1 NMLR 194.

[25] *Ibrahim v. Abdullahi* (1995) 6 NWLR (Pt. 392) 76

[26] I Sagay, 'Nigerian Law of Tort' (Ibadan: Spectrum Books, 1999)

"A shortfall in the activities of a health professional to maintain the standard of attention and expertise reasonably to be expected in the circumstances, resulting in harm suffered by a patient, for which there is legal redress."

**1.4 STATEMENT OF PROBLEM**

There is a lack of a comprehensive and effective legal framework specifically addressing medical negligence in Nigeria. Existing laws may be considered outdated, ambiguous, or insufficiently enforced, leading to challenges in holding healthcare professional accountable for negligence. One of such show of this problem is section 135(1) of the evidence act [27] which stipulate that "whoever desires any court to give judgement to any right or liability dependent on the existence of facts which he asserts must that those facts exists" while section 136 of the evidence act places the burden of proof on the person who would fail if no evidence was given on either side.

In Nigeria, negligence in medicine are tainted by a myriad of related problems both practical and legal that leave many victims of negligence without recourse and create suspicion in healthcare institutions.

The first hurdle in proving medical negligence is by itself a formidable barrier. The claimants must prove the four essential elements of negligence: duty of care, breach, causation, and harm. The courts require professional medical evidence; yet finding good expert witnesses often becomes expensive, scarce, or disputative. For example, in *Ojo v Gharoro*,[28] the loss by the appellant of expert evidence meant that her claim was struck out despite blatant evidence after surgical intervention of the presence of something foreign.[29]

Additionally, inadequate or unclear legislation is a cause. While the Medical and Dental Practitioners Act provides a framework for disciplinary measures and there are several ethical codes, there is no overarching law dealing with patient rights or a statute on medical negligence that clearly defines standards, burden of evidence, time limits, and other fundamental elements. Several judgments rely on general tort principles borrowed from English common law that may not fully take into consideration local conditions, e.g., shortages in resources, country doctors, and customs connected to keeping records.

Thirdly, ineffective enforcement and institutional capability are key issues. Institutions like the MDCN have jurisdiction and mandate, but they often lack adequate capacity, which will cause delay in investigation, failure to take actions, ineffective penalty or lack of publicity about the process of complaining. Despite disciplinary panels issuing suspension against practitioners at times, such actions may not act effectively as deterrent measures, especially where harm has occurred.

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[27] Section 135(1) of the Avidence act

[28] *Ojo v Gharoro* (2006) 10 NWLR (Pt. 987) 173.

[29] <https://nigerianlawforum.com/case-law/ojo-v-gharoro-2006/?utm>_ accessed 23rd September 2025

Fourthly, cost, access, and delay in litigation: civil suits are costly; most claimants are not represented in court; court backlogs; delay diminishes value of remedy. In criminal or disciplinary matters, rules of procedure, requirement for evidence, issues relating to jurisdiction frequently lead to dismissal or reversal of verdicts.

Fifthly, awareness and patient autonomy: lack of knowledge about rights among patients; cultural humility in front of doctors; inadequate informed consent; social or religious coercion. Okonkwo cites the tension when patients withhold consent from treatment, yet also underscores the importance of respecting patient autonomy. However, numerous contexts for treatment move forward without adequate disclosure or appropriate informing.

Finally, unequal justice: cities or economically prosperous citizens are more likely to sue; rural and disadvantaged citizens suffer in silence. Also, cases involving large or public hospitals may face resistance from politics or institutions. There is therefore an urgent task to delve into how law currently addresses medical negligence, identify where it falters, discuss decision-making in suitable cases (with relevant case law), and make reforms. Otherwise, without such attention, this rift between statute law and practical application will not vanish and will generate recurrent preventable harm to patients.

**1.5 OBJECTIVE OF STUDY**

The general purpose of this work is to attempt a holistic analysis of law and practice on medical negligence and malpractice in Nigeria with particular reference to finding lags and proposing corrective reforms. The specific purposes are:

1. In examining the idea, nature, and extent of Nigerian law on medical negligence.
2. In order to assess the rules relating to medical negligence from case laws, statute laws, and international laws.
3. In analyzing matters involving patients in prosecuting cases arising from medical negligence in Nigeria.
4. The scrutiny of adequacy of regulatory and disciplinary measures put in place by professional bodies such as the Medical and Dental Practitioners Act (Cap M8, LFN 2004)[30], is pertinent.
5. In suggesting reforms that would enhance patient safety and awaken responsibility among health care providers.

[30] Medical and Dental Practitioners Act (Cap M8, LFN 2004)

## 1.6 RESEARCH QUESTIONS

This study is guided by the subsequent research questions:

1. 1.What are the Nigerian laws relating to medical negligence?

2. How Nigerian courts have applied and interpreted rules relating to negligence in medicine in such cases as *Okonkwo v. MDPDT* and *Ojo v. Gharoro*.

3. What are the salient problems patients face in trying to sue for negligence in medicine in Nigeria?

4. How effective are disciplinary and regulatory bodies, e.g., the Medical and Dental Practitioners Disciplinary Tribunal, in preventing malpractice by professionals?

5. What amendments are possible to enhance patient rights and promote responsibility in Nigeria's health system?

## 1.7 SIGNIFICANCE OF STUDY

This research holds considerable importance for multiple reasons:

1. Academic contribution: This work contributes to the existing body of work on the issue of tort law and medical jurisprudence in Nigeria through an examination of the essence of medical negligence and its practice.

2. Relevance to Practice: The article gives informative insights, and it will assist physicians, lawyers, magistrates, and policymakers to balance professional autonomy and a patient's rights.

3. Social Implications: In uncovering systemic problems and recommending reform, this report stimulates increased responsibility for the healthcare delivery system and reinforces public trust in the practice of medicine.

4. Comparative Value: The study also draws on international perspectives, particularly from jurisdictions like the UK where the Bolam test originated, offering lessons for Nigerian law.

## 1.8 LIMITATION OF THE STUDY

The ambit of this work is restricted to medical negligence within the context of Nigeria, and it centers on civil liability for tort and professional sanction. Criminal liability (e.g., State of Lagos v. Orji) is also analyzed, albeit not as a focal point.

The study does not incorporate common negligence outside of the medical aspect, and it doesn't broach pure public health policy. Another hindering constraint is the few reported cases of medical negligence in Nigeria relative to jurisdictions such as the United Kingdom, making it difficult to analyze case laws. Lastly, using the secondary sources of textbooks, scholarly journal articles, and internet databases provides a constraint in terms of accessibility and recency of information.

## 1.9 METHODOLOGY

This work embraces a doctrinal legal inquiry approach and targets the in-depth examination of both the primary and secondary legal material.

Primary Sources: Court judgments involving Medical and Dental Practitioners Disciplinary *Tribunal v. Okonkwo, Ojo v. Gharoro, and State of Lagos v. Orji*; enactments of parliament like the Medical and Dental Practitioners Act; and constitutional provisions.

Secondary Sources: Academic law textbooks (e.g., Ese Malemi, Law of Tort), journal articles, Nigerian Law School lecture notes, and learned writings on tort and medical jurisprudence.

Electronic Databases: Access to internet-based legal databases such as NigeriaLII, HeinOnline, ResearchGate, and professional platforms for recent developments.

Doctrinal approach is suitable as it provides for a systematic analysis of the current law, judicial reasoning, and professional practice on medical negligence within a Nigerian framework.

# CHAPTER TWO
# CONCEPTUAL AND THEORETICAL FRAMEWORK

## 2.1 CONCEPT OF MEDICAL NEGLIGENCE

### 2.1.1 Introduction To The Concept

Medical Negligence: As a subset of the tort of negligence, medical negligence takes a very unique position at the converged point of law, medicine, and ethics in Nigeria. Medical negligence pertains to the situation where a healthcare provider fails to meet the standard of care, resulting in harm to a patient.[31] The issue is not just theoretical because it portrays the need to hold accountable a healthcare system with systemic deficiencies.[32]

[31] AO Okoye, 'Medical law in Nigeria' (Pretoria University Press, 2022) 45
[32] WHO, Patient Safety in Nigeria (2021) 12

The Nigerian system of law takes the tradition of common law and transplants basic principles from the jurisprudence of England to suit Nigeria[33]. This chapter defines the definition, elements, standard of care, great judicial cases, statutory laws, defenses, and remedies in detail with full citations and critical examination.

The ***Bolam principle*** has been judicially recognized and applied in Nigeria. In *Ojo v. Gharoro & Ors,* the Supreme Court emphasized that the mere occurrence of a mishap during medical treatment does not automatically imply negligence. The court held that the burden of proof rests on the claimant to establish that the doctor failed to exercise reasonable skill and care expected of a competent practitioner. This reflects the Nigerian judiciary's adherence to the Bolam test, requiring credible expert evidence to determine whether the standard of care was breached.[34]

Moreover, in *Medical & Dental Practitioners Disciplinary Tribunal v. Okonkwo*, the Supreme Court of Nigeria identified the balance between medical responsibility and a patient's autonomy in medical practice. The court held that a medical practitioner cannot be held negligent for respecting a patient's informed refusal of treatment on religious grounds, reaffirming that liability in negligence depends on breach of duty, not on moral judgment.[35]

In Nigeria, the legal basis of medical negligence is mainly anchored on the Tort liability tenets of duty of care, breach of duty, causation, and damage. All of these must be cumulatively proven. Also, a duty of care arises in a medical practice when medical personnel choose to diagnose/treat a patient. Breach of duty is established where medical personnel fails to meet the acceptable medical standards, and the plaintiff must demonstrate that he suffered damage as a result of the breach.

Also involved in the regulation of medical practice is the *Medical and Dental Practitioners Act*. This act enables disciplinary matters in the medical field to be handled by the Medical and Dental Council of Nigeria (MDCN). Section 16 of this act gives the Medical and Dental Practitioners Disciplinary Tribunal power to investigate any medical practitioner found guilty of "infamous conduct in a professional respect" that is gross negligence/incompetence.[36]

It has been observed that medical negligence not only refers to medical error, but any kind of medical misconduct that can pose a risk to a patient is also medical negligence. As stated by Ese Malemi, "a medical practitioner is expected to possess not only the requisite professional competence but also a humane disposition towards patients, since negligence may result from both ignorance and indifference." Today in Nigeria, there is a heightened awakening in the rights of patients, and medical negligence is one issue that is

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[33] .O Fagbemi, 'Common Law Transplantation in Nigeria Medical Jurisprudence' *AFR.J Leg. Stud* (2020) 201.

[34] (2006) 10 NWLR (Pt. 987) 173 (SC).

[35] (2001) 7 NWLR (Pt. 711) 206 (SC).

[36] Medical and Dental Practitioners Act (Cap M8, LFN 2004).

presently on the legal discussion table. It is evident that in cases like _State of *Lagos v. Dr. Ejike Ferdinand Orji* medical neglect could result in criminal liability if there is a reckless disregard for human life.[37]

This is a reflection of the increasing acceptance of the idea that patient safety is a public issue. In concluding, the notion of medical negligence in Nigeria entails the adoption of a general principle of negligence in a medical practice. Establishing medical negligence necessitates a thorough analysis of a medical practitioner's act, the accepted standards in this field, as well as the particular circumstances of a given situation. This notion of medical negligence is constantly developing via judicial interpretations.

**2.2 DEFINITION OF MEDICAL NEGLIGENCE**

Medical negligence occurs when a healthcare provider, who owes a duty of care to a patient, breaches the standard of care expected of a reasonably competent practitioner in that field under similar circumstances, and the breach directly causes injury, harm or death to the patient. Medical negligence is a specific branch of tort law that deals with the failure of a medical professional to exercise the standard of care and skill expected of a reasonably competent practitioner, leading to injury, loss, or death of a patient. It rests on the classic negligence triad: duty of care, breach of that duty, and resultant damage.

According to Ese Malemi, medical negligence occurs when a medical practitioner fails to exercise reasonable care and skill in the treatment of a patient, resulting in injury or death. He further explains that the law imposes a duty on doctors to bring to their task a reasonable degree of skill and knowledge, and to exercise reasonable care in attending to their patients[38].

Similarly, *I.O. Smith* defines medical negligence as a failure by a medical professional to meet the standard of care that a reasonably competent practitioner would have met in the same situation, resulting in harm to the patient.[39]

In addition, Black's Law Dictionary 11th ed defines negligence as:

"The failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; any conduct that falls below the legal standard established to protect others against unreasonable risk of harm."[40]

When applied to medicine, the term "medical negligence" thus implies a professional deviation from accepted medical practice.

**2.2.1 JUDICIAL DEFINITION**

The earliest judicial definition of negligence comes from *Blyth v. Birmingham Waterworks Co*, where Alderson B. stated: "Negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the

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[37] Charge No. LD/8963C/2019 (Unreported, Lagos High Court, 2023).
[38] Ese Malemi, 'Law of Tort' (Princeton Publishing Co., Lagos, 2019) 245–247
[39] I.O. Smith, *Nigerian Law of Torts* (Ecowatch Publications, Lagos, 2013) 322
[40] *Black's Law Dictionary* (11th ed., Thomson Reuters, 2019) 1256

conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do."[41] Although this case did not involve medical practice, its general definition forms the foundation for medical negligence law globally, including Nigeria. In *Ojo* v *Gharoro & Ors*, the Supreme Court of Nigeria held that "A medical practitioner is not expected to bring the highest possible degree of skill to bear, but only such reasonable degree of skill and care as is ordinarily exercised by members of the profession of good standing."[42]

The case involved a woman who died following complications during childbirth allegedly caused by the negligence of her doctor. The court reaffirmed that liability depends on whether the doctor's conduct fell below that of a reasonably competent practitioner.

Similarly, in ***Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*****,** the Supreme Court reiterated that doctors owe a duty of care to their patients, which extends to diagnosis, treatment, and post-treatment monitoring. The court held that failure to exercise reasonable care and diligence constitutes professional misconduct and actionable negligence.[43]

In *University of Benin Teaching Hospital Management Board v. Akhiwu*, though not widely reported, the court defined medical negligence as:

"A breach of duty by a medical practitioner in failing to provide the standard of care which a reasonably competent practitioner in that field would have provided under similar circumstances."

The case is widely cited in Nigerian legal literature, especially by Ese Malemi and Smith, as an authority for defining the standard of medical care.

Furthermore, in *Abatan v. Awudu*, the court recognized that hospital authorities can be vicariously liable for the negligent acts of their employees, or for institutional negligence such as failure to provide essential facilities or emergency response.[44]

**2.2.2 MODERN PERSPECTIVE**.

Contemporary Nigerian jurisprudence increasingly recognizes *institutional and systemic negligence* where liability arises not only from the doctor's act or omission but from administrative lapses in hospitals. The courts have also emphasized the need for informed consent, timely diagnosis, and patient communication.

The neighbor principle laid down in *Donoghue v. Stevenson* remains the moral and legal foundation for all negligence claims, including medical negligence, establishing that one must take reasonable care to avoid acts or omissions likely to injure one's neighbor that is, those closely and directly affected by one's actions.

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[41] Blyth v. Birmingham Waterworks Co. (1856) 11 Exch. 781, [1856]
[42] (2006) 10 NWLR (Pt. 987) 173
[43] (2002) 14 NWLR (Pt. 788) 1.
[44] 9 NWLR (Pt. 773) 653.

## 2.3 ELEMENTS OF MEDICAL NEGLIGENCE

In order for a plaintiff to win a case of medical negligence, it is important that several key elements be proved. From common law as practiced in English law, four elements must be proved in a medical negligence claim, including duty of care, breach of duty, causation, and damage or injury.[45] The law does not impose absolute liability against medical practitioners, though it demands that they exercise a reasonable standard of skill, diligence, and care that an ordinarily prudent medical practitioner is expected to observe in such circumstances. In determining a claim against medical negligence, therefore, it is pertinent to examine all three criteria in relation to medical practice.

### 2.3.1 DUTY OF CARE.

First of all, in a claim for medical negligence, it is imperative that a duty of care is owed by the medical practitioner to the plaintiff. This duty of care is owed as soon as a relationship is created between the doctor and his or her patient. In the famous case of *Donoghue v. Stevenson, Lord Atkin* introduced the "neighbour principle," stating that "a person must take reasonable care to avoid acts or omissions likely to cause injury to his neighbor.[46] By neighbor, I associate all persons who are so closely and directly affected by his actions that they have a foreseeable claim upon his care with reference to those actions." This is basically the foundation of all negligence claims, including those of medical negligence. This was reiterated by the Supreme Court of Nigeria in the case of *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*, that a doctor owes a duty of care to his patient not only in treatment but also in adequate information, obtaining consent, and after-care.[47] In this aspect, it was highlighted that the duty of care starts as soon as a doctor-patient relationship is created.

Likewise, in *Ojo v. Gharoro & Ors*, it was held that "when a patient consults a doctor for his advice or treatment, it is a duty of that doctor to exercise care and skill."[48] This implies that a doctor is under a strict duty to act in a manner that is in line with expectations. In *Cassidy v. Ministry of Health*, Denning-Lord said that hospitals owe a non-delegable duty of care to see that all medical staff work with reasonable competence regardless of their hierarchical status in the hospital.[49] This precedent was followed in Nigeria, as hospitals have been held vicariously liable for negligence perpetrated by its employees.

### 2.3.2 BREACH OF DUTY.

As a second step, having established that a duty of care exists, the plaintiff needs to prove that the medical practitioner breached that duty. A breach is when the doctor's conduct falls below the standard expected of a reasonably competent practitioner in that field. The

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[45] Ese Malemi, 'Law of Tort' (Princeton Publishing Co., Lagos, 2019) 248–250.
[46] (1932) AC 562.
[47] (2002) 14 NWLR (Pt. 788) 1
[48] (2006) 10 NWLR (Pt. 987) 173
[49] (1951) 2 KB 343.

Bolam test, laid down in the case of *Bolam v. Friern Hospital Management Committee*, provides the standard for determining breach in medical negligence. McNair J. held that: "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."[50] This principle has gained wide acceptance in Nigeria as the standard upon which professional negligence is measured.

The Supreme Court in *Ojo v. Gharoro & Ors* , applying the Bolam principle, held that the test is not whether the court considers the doctor's conduct negligent but whether the conduct would be regarded as acceptable by a responsible body of medical opinion in that specialty. In the case of *Esangbedo v. State*, the Supreme Court held that where a professional, through an omission or by being careless, acts in a manner inconsistent with established standards of his profession, such act constitutes gross negligence.[51]

**2.3.3 CAUSATION**.

In establishing causation, the plaintiff has to show that there is a causal relationship between the defendant's breach of duty and the injury incurred. It is not sufficient to prove that there was negligence; it needs to be proved that the negligence either caused or materially contributed to the harm. In *Barnett v. Chelsea and Kensington Hospital Management Committee*, the court held that although the hospital had been negligent in not attending to a patient, the patient would have died of arsenic poisoning anyway. As a result, negligence was not considered to be the proximate cause of death.[52] This reasoning has been adopted in Nigerian jurisprudence, notably in *Ojo v. Gharoro,* where the court required proof that the alleged negligence caused or substantially contributed to the patient's death.

The principle *of res ipsa loquitur* the thing speaks for itself-sometimes helps plaintiffs establish causation when direct evidence is absent, for example in surgical cases where a foreign object is left inside a patient's body. However, the Nigerian courts apply this principle with restraint, as a means of ensuring that it does not become a substitute for the burden of proof.

[50] (1957) 1 WLR 582
[51] (1989) 4 NWLR (Pt. 113) 57.
[52] (1969) 1 QB 428.

### 2.3.4 DAMAGE.

The plaintiff finally needs to prove that he suffered actual damage, whether physical, mental, or financial, as a direct consequence of the doctor's breach of duty. Damage may include pain and suffering, loss of earnings, additional medical expenses, or permanent disability. In *Abatan v. Awudu*, the Court of Appeal held that damages in medical negligence cases must be compensatory rather than punitive, and should be based on proven injury directly traceable to the negligent act.[53]

In the same way, in *Okonkwo v. MDPDT*, the Supreme Court reiterated that not every medical mistake constitutes negligence; compensation arises only in cases where the breach of duty results in actual harm or loss to the patient.

## 2.4 MEANING OF MEDICAL NEGLIGENCE.

As earlier discussed, medical negligence refers to a **failure to exercise the degree of care, skill, and diligence that a reasonable medical practitioner would exercise under similar circumstances,** leading to injury to a patient. It is rooted in the tort of negligence, which focuses on compensating the victim rather than punishing the wrongdoer. The Nigerian Supreme Court in ***Ojo v. Gharoro & Ors*** defined a negligent doctor as one who fails to bring to his task the reasonable degree of skill and knowledge ordinarily exercised by competent members of the profession of good standing.[54]

In ***Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal,*** the court reaffirmed that a medical practitioner is only expected to exercise reasonable care, not perfection. Hence, negligence may occur from error of judgment or omission without moral blame.[55] Thus, medical negligence is **unintentional** it arises from oversight, mistake, or omission in diagnosis, treatment, or post-operative care, even though the practitioner meant no harm.

### 2.4.1 PRACTICAL IMPLICATIONS IN NIGERIAN LAW.

In Nigeria, claims for medical negligence are usually pursued in civil courts for damages. The Tribunal, established under the Medical and Dental Practitioners Act, investigates

[53] (2002) 9 NWLR (Pt. 773) 653.
[54] (2006) 10 NWLR (Pt. 987) 173
[55] (2002) 14 NWLR (Pt. 788) 1

allegations of infamous conduct in a professional respect, which includes reckless treatment, unethical behavior, falsification of medical records, or practicing under the influence of intoxicants. Hence, the concepts protect patients' rights, and emphasizes compensation for harm.

**2.5 THEORIES OF LIABILITY IN MEDICAL PRACTICE**

Medical liability in the Nigerian setting refers to a situation where a medical practitioner, as a result of an act or omission, does harm to a patient, contrary to a legal duty of care. The assessment of such liability is based on a number of theories, as can be considered within tortious and professional liability, which form the foundation on which the medical practitioner's conduct is evaluated.

**1.The Tortious Theory of Liability (Negligence-Based Liability)**

The tortious basis remains the most famous medical liability foundation. It is founded on the common law obligation of care, which binds medical practitioners towards their patients. The tortious basis finds its foundation in the famous maxim introduced in the case of *Donoghue v. Stevenson*[56] where the famous 'neighbour principle' maxim was introduced *by Lord Atkin*, which states a person has to exercise care so as not to do anything, which can result in foreseeable harm to his neighbour.

In the medical setting, this tenet took a form in the case *of Bolam v. Friern Hospital Management Committee*[57], as it was held that a doctor will not be liable for negligence if he acts in accordance with practice accepted as proper by a responsible body of medical men skilled in that particular art. This test has been frequently cited in Nigerian cases. The Bolam test has often been cited in cases. For example, in the case of *Ojo v. Gharoro & ors* [58], supra, the court reiterated the fact that a medical practitioner owes a duty of care to his patient to exercise a reasonable degree of care, skill, and competence, while a breach of such a duty amounts to actionable negligence. Again, in the case of *Abatan v. Awudu*[59], it was held that a medical practitioner's failure to diagnose a patient's condition amounts to actionable negligence.

Accordingly, under the tortious theory, liability requires proof of the following elements:

(a) that the defendant owed a duty of care to the claimant;

(b) that the duty was breached; and

(c) that the breach of contract caused the claimant some injury.[60]

**2. The Contractual Theory of Liability**

The contractual approach arises where a relationship between a patient and a doctor is governed by a contract. Where a patient seeks the services of a doctor on a private basis,

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[56] (*1932) AC 562*,

[57] [1957] 1 WLR 582.

[58] (2006) 10 NWLR (Pt. 987) 173

[59] (2002) FWLR (Pt. 124) 398

[60] Ese Malemi, (n45)

a contract arises, implying that the doctor will use a degree of skill and care. A breach of this can result in liability on the basis of contract, without regard to the tort of negligence. In the case of *Allison v. General Council of Medical Education and Registration*[61], it has been held that a doctor's promise to treat a patient necessarily involves an implied contract of care analogous to tort, and a breach thereof can be a breach of contract. The aforesaid case has been recognized in Nigeria, as held in *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*[62], wherein it has been held by the Supreme Court of Nigeria that a doctor's relationship with a patient could well be a contract as well as a fiduciary relationship. Even as remedies in tort aim at compensating a person for injury, remedies for breach of contract can be founded on damages, up to a level of rescinding a contract, based on the agreement reached. More specifically, contractual liability does not rely on proof of negligence, as it relates to the agreement set between parties.[63]

**3. The Criminal Theory of Liability**

In the event where the act of a medical practitioner goes beyond the ambit of a civil wrong, assumes a criminal nature, as in the case of serious negligence culminating in death, the criminal law steps in. Section 303 of the Criminal Code Act provides that a person purporting to administer surgical or medical treatment must have a reasonable skill and exercise reasonable care, default of which can be considered criminal negligence or manslaughter.[64]

In the case of *R v. Adomako*[65], the House of Lords asserted a doctor could be prosecuted for the crime of gross negligence manslaughter as a result of negligent conduct so bad as to be criminal. The decision has been cited in Nigerian cases in interpreting Section 303 of the Criminal Code. For example, in *Ogunbanjo v. State*[66], the Court of Appeal confirmed a conviction for criminal negligence in a case where a medical doctor's reckless indifference to life caused the death of a patient.

**4. The Fiduciary Theory of Liability**

In addition to tort law, contract law, the fiduciary approach highlights the moral nature of trust between a physician and a patient. A fiduciary relationship requires a physician to display the highest level of good faith, loyalty, and honesty vis-à-vis a patient. Violation of such a relationship, for example, in regard to the unauthorized disclosure of a patient's confidentiality, would be considered unprofessional conduct under the *Medical & Dental Practitioners Act.*[67] In the case of *Okonkwo v. M.D.P.D.T (supra)*, it has been held by the

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[61] (1894) 1 QB 750
[62] (2001) 7 NWLR (Pt. 711) 206.
[63] Niki Tobi, 'Law of Contract in Nigeria' (M.I.J. Professional Publishers Ltd, Lagos, 2010) 312.
[64] Criminal Code Act, Cap. C38, Laws of the Federation of Nigeria 2004, s.303
[65] [1995] 1 AC 171
[66] (2001), FWLR (Pt 78), 1108
[67] Medical and Dental Practitioners Act, Cap. M8, Laws of the Federation of Nigeria 2004

Supreme Court that the relationship of doctor and patient is based on trust, as a result of which, practitioners are expected to respect patients' autonomy and consent rights.

In summary, the theories of liability in medical practice tortious, contractual, criminal, and fiduciary collectively underpin the accountability framework of healthcare law in Nigeria. While tort and contract ensure compensation and redress, criminal and fiduciary theories protect societal and ethical interests. The convergence of these doctrines underscores the multidimensional nature of medical law and the critical role of judicial oversight in ensuring professional responsibility.

## 2.6 CONCLUSION

Medical negligence remain deeply entrenched challenges within Nigeria's healthcare and legal systems. Although the law recognises the duty of medical practitioners to exercise reasonable care and skill, the enforcement of this obligation is frequently undermined by systemic deficiencies such as weak regulatory oversight, inadequate disciplinary mechanisms, poor documentation practices, lack of awareness of patient rights, and the inherent complexity of proving negligence in court. While decisions such as *Ojo v. Gharoro* and *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* affirm judicial willingness to uphold medical accountability, the practical realities of litigation—including the burden of proof, cost of expert testimony, and slow judicial processes—continue to prevent many victims from obtaining redress.

The work has demonstrated that Nigeria's legal framework, including constitutional guarantees under section 33 and 34, statutory provisions in the National Health Act 2014, and consumer protection mechanisms under the FCCPA 2019, provides a foundational basis for accountability in medical practice. However, the absence of effective implementation significantly diminishes their protective value. The regulatory bodies, especially the Medical and Dental Council of Nigeria (MDCN), possess disciplinary powers on paper, yet delays, procedural opacity, and institutional constraints often render

the system unresponsive to complaints. The gap between legal obligations and actual enforcement creates a climate in which substandard medical practice may persist without meaningful consequences.

Drawing from the challenges identified, this study offers key recommendations aimed at strengthening enforcement: the establishment of specialised medical negligence tribunals, mandatory professional indemnity insurance, improved disciplinary frameworks, enhanced implementation of the Patients' Bill of Rights, adoption of alternative dispute resolution mechanisms, digitalisation of health records, and the development of targeted capacity-building programmes for legal and medical professionals. If adopted, these measures have the potential to significantly enhance transparency, reduce delays, and guarantee more effective protection for patients while encouraging higher standards of professional conduct among medical practitioners.

# CHAPTER THREE
# LEGAL AND JUDICIAL RESPONSES TO MEDICAL NEGLIGENCE IN NIGERIA

## 3.1 INTRODUCTION

Medical negligence, as a subset of the tort of negligence, arises when a medical practitioner fails to exercise the degree of care and skill reasonably expected of a competent professional in similar circumstances, resulting in harm to the patient. Nigerian courts, guided by the common law heritage, have consistently upheld the Bolam principle as the standard for determining medical negligence, requiring conformity with the conduct accepted as proper by a responsible body of medical professionals. The courts have also adopted the Bolitho refinement, emphasizing that professional opinion must withstand logical analysis before exonerating a practitioner.

The principal statute regulating medical practice in Nigeria is the Medical and Dental Practitioners Act[68], which establishes the Medical and Dental Council of Nigeria (MDCN) as the supervisory and disciplinary authority for medical and dental practitioners. The MDCN is empowered to maintain professional standards, issue licenses, and discipline practitioners found guilty of infamous conduct or professional misconduct. Through its Disciplinary Tribunal, the Council investigates and sanctions cases of malpractice, including gross incompetence, unethical conduct, or criminal behavior. However, while the MDCN has statutory powers to discipline erring practitioners, it does not provide compensation to victims of negligence—leaving civil courts as the primary avenue for redress.

[68] Cap M8, Laws of the Federation of Nigeria 2004

In addition to statutory regulation, case law plays a crucial role in shaping the Nigerian medico-legal landscape. Decisions such as *Abatan v. Awudu*[69] and *Okonkwo v. Medical and Dental Practitioners Council of Nigeria*[70] have elaborated on the scope of medical liability, patients' rights, and the standards of professional accountability. These cases illustrate the judiciary's evolving approach towards balancing the protection of patient welfare with the recognition of medical practitioners' professional discretion.

The Constitution of the Federal Republic of Nigeria 1999 (as amended) also indirectly influences the legal regime on medical negligence through its guarantees of the right to life (Section 33), right to human dignity (Section 34), and right to health (implicit under Chapter II). While these rights are primarily enforced against the state, they underscore the importance of ethical and professional standards in the medical sector. Furthermore, criminal statutes such as the *Criminal Code Act*[71] and the *Penal Code Act*[72] provide sanctions for acts of gross negligence or recklessness leading to death or grievous harm, including manslaughter by negligence under Section 303 of the Criminal Code.

Nigeria also aligns with several international human rights instruments, such as the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, which guarantees the right to health and obliges the state to protect citizens against professional abuse. Despite these frameworks, enforcement mechanisms remain weak due to systemic inefficiencies, limited access to justice, and lack of awareness among patients regarding their legal rights.

In essence, the legal framework for medical negligence in Nigeria operates on three interrelated pillars:

1. Common law principles of negligence (duty of care, breach, causation, and damage);
2. Statutory regulation through the Medical and Dental Practitioners Act and related healthcare laws; and
3. Ethical codes and disciplinary oversight under the MDCN and related professional bodies.

However, while the structure appears comprehensive in theory, its practical implementation reveals significant gaps in accountability, enforcement, and

[69] (2002) 11 NWLR (Pt. 778) 148.
[70] (1999) 9 NWLR (Pt. 617) 54.
[71] Cap C38 LFN 2004
[72] Cap P3 LFN 2004

compensation, thereby necessitating a review of Nigeria's medico-legal architecture in light of international standards.

### 3.2 CONSTITUTIONAL PROVISIONS ON HEALTH AND RIGHTS

The regulation of medical negligence and malpractice in Nigeria is underpinned not only by tort and statutory frameworks, but also by constitutional guarantees of fundamental human rights. The Constitution of the Federal Republic of Nigeria 1999 (as amended) (hereafter "the Constitution") enshrines rights which bear directly upon medical practice—most notably the rights to life, human dignity, personal liberty, privacy, and the protection against discrimination. These provisions impose a legal and ethical duty upon medical practitioners and institutions to act in a manner consistent with the patient's rights. Furthermore, international legal instruments and regional treaties to which Nigeria is a party strengthen and contextualize these rights within the healthcare sector.

**Key Constitutional Rights Related to Health**

**Right to Life** — Section 33(1) of the Constitution provides:

"Every person has a right to life, and no one shall be deprived of such right except in the manner prescribed by law."

This provision has been interpreted in Nigerian jurisprudence to impose a duty upon the medical system and practitioners to preserve life, which implicates medical negligence when undue harm or death occurs through medical error or omission. For instance, the right to life is identified in scholarship as the anchor of health rights in Nigeria.[73]

**Right to Human Dignity** — Section 34(1)(a) states:

"Every individual is entitled to respect for the dignity of his person, and no person shall be subjected to torture or to inhuman or degrading treatment."

The dignity guarantee involves the right of patients to be treated humanely and with dignity by receiving adequate care and not being subjected to degrading medical treatment. The denial of adequate medical treatment or the exposure of patients to unsafe medical practices may amount to a violation of this constitutional right.[74]

**Right to Personal Liberty and Security of the Person**: Section 35 provides for personal liberty and security of the person. In the context of medical practice,

arbitrary detention in hospital, forced treatment without consent, or undue deprivation of liberty in the medical setting may raise this right.[75]

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[73] J Shajobi-Ibikunle and VAN Aja, 'Right to Health of the Nigerian Child: Challenges and Prospects' BSU Law Journal (2021)10.

[74] 'The Right to Health Under the Nigerian Constitution: Myth or Reality?' *LawYard* (2024) <https://www.lawyard.org/opinions/the-right-to-health-under-the-nigerian-constitution-myth-or-reality/> 11th November 2025

[75] O Olumese, 'Duty without Liability: The Impact of Article 12 of the International Covenant on Economic, Social and Cultural Rights on the Right to Health Care in Nigeria' *African Human Rights Law Journal* (2021) 1112-1134.

**Right to Privacy, Freedom of Thought, Conscience, and Religion**: Sections 37 and 38 guarantee the right to privacy and freedom of religion/conscience. These rights have a bearing on informed consent, refusal of medical treatment, confidentiality of patient records, and patient decision-making in healthcare.[76]

**Socio-Economic Rights and Right to Health** — While the Constitution does not expressly provide for a "right to health," Section 17(3)(a) and Section 18(1)(c) state that the State shall direct its policy towards ensuring adequate medical and health-care services for all persons. These are found in Chapter II (Fundamental Objectives and Directive Principles of State Policy), which are not directly justiciable under Section 6(6)(c).[77] However, courts and scholarship more and more derive health rights through the justiciable civil/political rights (e.g., life and dignity) along with international treaties. [78]

**Judicial and Scholarly Authorities**

In *Gbemre v. Shell Petroleum Development Company Nigeria Ltd.* (though environmental context) the Federal High Court recognised that the right to life encompasses the right to a healthy environment. That reasoning has been cited in the health-rights context.[79]

Scholarship argues that the right to health in Nigeria is *derivable* from the rights to life and dignity, and that the ouster of Chapter II justiciability should not preclude enforcement of health-care standards. For example, Olumese argues in "Duty Without Liability: The Impact of Article 12 of the International Covenant on Economic, Social and Cultural Rights on the Right to Health Care in Nigeria" (2021) 21 African Human Rights Law Journal 1112-1134, that health rights should be seen as integral to fundamental rights.[80]

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[76] National Human Rights Commission, 'Right to Health' <https://www.nigeriarights.gov.ng/focus-areas/right-to-health.html> 11th November 2025

[77] ss 17(3)(a), 18(1)(c), 6(6)(c).

[78] IT Imoban, 'Right to Health Under Nigerian Law; The Justiciability and Otherwise' *BarristerNG.com* (2024) <https://barristerng.com/right-to-health-under-the-nigerian-law-the-justiciability-and-otherwise-by-i-t-imoban-esq/> 11th November, 2025

[79] (2019) 5 NWLR (Pt 1666) 518.

[80] O Olumese (n87)

According to the National Human Rights Commission website, the right to health is recognised under international law and is relevant for medical service-users, including in complaints of negligence and malpractice.[81]

**Application to Medical Negligence**

The constitutional rights cited above provide a basis for claims of medical negligence in several ways:

**Duty of the State/Practitioner**: The right to life and dignity means that medical practitioners and institutions must act with reasonable skill and care. A breach that causes death or serious harm may therefore implicate Section 33 and Section 34 rights.

**Refusal of Treatment / Informed Consent**: Rights to privacy, conscience and religion support the principle that patients must be adequately informed and allowed to refuse treatment. Failure by a practitioner to respect such rights may amount to malpractice or unethical conduct.

**Hospital Liability**: Where hospitals or the State fail to provide adequate health-care infrastructure, equipment or skilled personnel, resulting in harm, this may constitute a violation of the rights to life and dignity by omission.

**Enforcement Challenges**: Since Chapter II is not justiciable, litigants often invoke rights in Chapter IV (such as life, dignity) as the basis of enforcing health-care rights. E.g., in medical negligence, a claim may be framed as deprivation of life or degrading treatment.[82]

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[81] National Human Rights Commission, (n88)

[82] Vanguard, 'Whither the Right to Health in Nigeria?' (2021) <https://www.vanguardngr.com/2021/08/whither-the-right-to-health-in-nigeria/> 11th November 2025

In summary, while Nigeria does not yet recognize an express "right to health" in a justiciable form, the Constitution's guarantees of life, dignity, liberty, privacy, and the duty of the State to provide health-care services form a robust foundation for asserting rights in the context of medical negligence and malpractice. The interplay of these rights with medical regulatory frameworks enables patients to pursue claims when medical errors or misconduct occur. However, the judicial recognition of health rights remains evolving, and further development is necessary to ensure full protection of patients' interests.

### 3.3 RELEVANT STATUSES AND REGULATIONS

Medical negligence and malpractice in Nigeria are governed by a mix of **statutory instruments, regulatory codes,** and **common-law principles** inherited from English jurisprudence. The statutory and regulatory framework defines professional standards, patient rights, and institutional responsibilities while complementing the tortious remedies available under the common law. However, Nigeria's medico-legal environment remains fragmented, with various pieces of legislation addressing specific aspects of medical practice, patient safety, and health administration. The following are the principal statutes and regulations relevant to medical negligence and malpractice in Nigeria.

#### 3.3.1 The Medical and Dental Practitioners Act (Cap M8, LFN 2004)

This is the **principal legislation** regulating medical and dental practitioners in Nigeria. It establishes the **Medical and Dental Council of Nigeria (MDCN),** the **Medical and**

**Dental Practitioners Disciplinary Tribunal (MDPDT),** and provides the framework for registration, discipline, and ethical standards.[83]

Section 15 of the Act empowers the Tribunal to try practitioners for "infamous conduct in a professional respect," while Section 16 authorises the suspension or striking off of practitioners found guilty of such misconduct.[84] The Act thereby provides a quasi-judicial mechanism for accountability in medical practice.

In ***Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo***[85] the Supreme Court affirmed the authority of the Tribunal under this Act and recognised the intersection between medical ethics and patients' constitutional rights to autonomy and dignity. Scholars have noted that while the Act provides an institutional mechanism for discipline, it does **not directly provide for compensation to patients,** hence civil actions in tort remain necessary.

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[83] Medical and Dental Practitioners Act, Cap M8, LFN 2004, s. 15.
[84] Ibid., s. 16.
[85] (2001) 7 NWLR (Pt 711) 206 (SC),

### 3.3.2 The National Health Act 2014

The National Health Act 2014 (NHA) is Nigeria's most comprehensive statute addressing patients' rights and healthcare service obligations. It consolidates the regulation of healthcare delivery at federal, state, and local levels.

**Section 20** requires informed consent before medical treatment except in emergencies, while **Section 23(1)** guarantees patient confidentiality. **Section 26** establishes an Office of the Health Ombudsman to receive complaints about medical services.[86]

This Act brings Nigeria in line with international best practices on patient centred care. In ***Medical and Dental Council of Nigeria v. Okonkwo***, the Supreme Court affirmed that the right to self-determination in medical decisions is an extension of constitutional rights to dignity and freedom of conscience.[87]

### 3.3.3 The Federal Competition and Consumer Protection Act 2018

The Federal Competition and Consumer Protection Act 2018 (FCCPA) introduces a novel dimension to healthcare liability in Nigeria by recognising patients as **consumers of medical services.** Under **Section 120(1)**, service providers are required to ensure that the quality and safety of goods and services meet reasonable expectations.[88] This section applies to hospitals, clinics, and practitioners offering paid healthcare services.

Legal commentators contend that this provision allows patients to pursue remedies through consumer-protection mechanisms without necessarily invoking tort law, especially where sub-standard services cause harm.[89]

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[86] National Health Act 2014, ss. 20, 23 and 26.
[87] *MDCN v. Okonkwo* (supra)
[88] Federal Competition and Consumer Protection Act 2018, s. 120(1)
[89] A. O. Oshisanya, *An Almanac of Contemporary Judicial Restatements (Civil and Criminal Law)* (2nd edn, 2018) p. 89

### 3.3.4 The Criminal Code and Penal Code

Criminal liability may arise where medical negligence amounts to recklessness or gross carelessness. **Section 303** of the *Criminal Code Act (Cap C38, LFN 2004)* provides that any person undertaking medical treatment who, through gross negligence, causes death is guilty of manslaughter.[90] Likewise, **Section 213** of the *Penal Code Act (Cap P3, LFN 2004)* creates a similar offence applicable in Northern Nigeria.[91]

A notable illustration is ***State v. Dr Ferdinand Ejike Orji*** where a medical practitioner was convicted for reckless and negligent treatment leading to patient harm, affirming criminal accountability in medical malpractice.[92]

**Professional Codes and Institutional Regulations**

The **Code of Medical Ethics in Nigeria (2008)**, issued under the MDCN Act, complements statutory provisions by defining professional conduct, informed consent standards, and the doctor–patient relationship.[93]

Similarly, the **Rules of Professional Conduct for Medical and Dental Practitioners (1995)** guide professional behaviour and reinforce ethical obligations, such as maintaining confidentiality, competence, and integrity.[94]

State-level health laws, such as the **Lagos State Health Law 2015**, also supplement federal statutes by providing for facility accreditation, monitoring, and patient protection mechanisms.[95]

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[90] Criminal Code Act (Cap C38, LFN 2004), s. 303
[91] Penal Code Act (Cap P3, LFN 2004), s. 213.
[92] (High Court of Lagos, 2023, unreported). Reported summary at <https://thisdaylive.com> 13th November 2025
[93] Code of Medical Ethics in Nigeria (2008), Rule 19.
[94] Rules of Professional Conduct for Medical and Dental Practitioners (1995), s. 8.
[95] Lagos State Health Law 2015, ss. 3 and 5.

**Observed Challenges**

Despite the legal framework, gaps remain in enforcement and accessibility. The disciplinary and regulatory mechanisms of the MDCN are under-resourced and slow, while the Ombudsman under the NHA remains largely inactive. There is also a lack of public awareness about available statutory remedies beyond civil litigation. Scholars advocate for the creation of a **specialised medical negligence tribunal** to harmonise the various mechanisms of redress.

Nigeria's statutory and regulatory regime for medical negligence and malpractice represents a progressive blend of professional self-regulation, patient protection, and consumer accountability. However, the effectiveness of these instruments depends on enforcement, inter-agency coordination, and public education. To strengthen patient safety, legal reforms should aim to simplify redress processes and integrate professional and civil remedies under a unified medico-legal framework.

## 3.4 ROLES OF REGULATORY BODIES IN ADDRESSING MEDICAL NEGLIGENCE AND MALPRACTICE IN NIGERIA

Regulatory bodies play an indispensable role in maintaining professional standards, enforcing ethical conduct, and ensuring accountability in medical practice in Nigeria. Their mandates stem from various statutory instruments, most notably the Medical and Dental Practitioners Act, the Nursing and Midwifery (Registration, etc.) Act, and the National Health Act 2014. These institutions complement the judiciary by providing disciplinary oversight and administrative remedies for professional misconduct and negligence.[96]

The existence of these bodies reflects the recognition that self-regulation within the medical profession, backed by statutory authority, is essential to uphold patient safety, ensure competent practice, and restore public confidence in the health system.

[96] Ese Malemi, *Law of Tort* (Princeton Publishing Co., Lagos, 2019) 245.

### 3.4.1 The Medical and Dental Council of Nigeria (MDCN)

The **Medical and Dental Council of Nigeria (MDCN)** is the **primary regulatory authority** for medical and dental practitioners. It is established under Section 1 of the Medical and Dental Practitioners Act (Cap M8, LFN 2004).[97]

The MDCN performs several critical functions:

**i Registration and licensing** of qualified medical and dental practitioners (s. 7);

**ii Maintenance of professional standards** through continuing education;

**iii Disciplinary control** via its **Medical and Dental Practitioners Disciplinary Tribunal (MDPDT)** and **Investigating Panel**.[98]

In ***Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo***, the Supreme Court affirmed that the Tribunal has authority to try medical practitioners for "infamous conduct in a professional respect."[99] The Court also clarified that professional regulation must operate within the framework of constitutional rights, especially autonomy and dignity of patients.[100]

Recent MDCN decisions have involved suspension or deregistration of practitioners for negligence, professional misconduct, or unethical practice. However, scholars observe that the disciplinary process is **slow and underfunded**, often discouraging complainants.

### 3.4.2 Nursing and Midwifery Council of Nigeria (NMCN)

The **Nursing and Midwifery Council of Nigeria (NMCN),** established under the *Nursing and Midwifery (Registration, etc.) Act (Cap N143, LFN 2004)*, regulates nursing and midwifery practice in Nigeria. Its statutory responsibilities include:

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[97] Medical and Dental Practitioners Act, Cap M8, LFN 2004, s. 1.
[98] Ibid ss. 7, 15–18
[99] (2001) 7 NWLR (Pt 711) 206 (SC). <https://lawcarenigeria.com> 13 November 2025
[100] Ibid., 236–239 (per Ayoola JSC).

Regulating **education and training** of nurses and midwives;

Licensing practitioners;

Investigating cases of **professional negligence, misconduct, or incompetence**; and

Maintaining the **Register of Practitioners**.[101]

The Council's disciplinary powers are exercised through the **Investigating Panel** and **Disciplinary Committee**, which can impose sanctions including suspension, withdrawal of licence, or referral to criminal authorities.[102]

### 3.4.3 Pharmacists Council of Nigeria (PCN)

The **Pharmacists Council of Nigeria (PCN)** is established under the *Pharmacists Council of Nigeria Act*. Its role in the broader context of medical negligence includes ensuring that only **qualified pharmacists'** compound, dispense, and distribute drugs, thereby reducing cases of pharmaceutical malpractice.[103]

The PCN regulates the **issuance of licences**, conducts **inspection of pharmaceutical premises,** and maintains a **Disciplinary Tribunal** to sanction unethical or negligent conduct among pharmacists.[104] Negligent dispensing of expired or counterfeit drugs may attract sanctions under both the PCN Act and the Counterfeit and Fake Drugs.[105]

### 3.4.4 National Agency for Food and Drug Administration and Control (NAFDAC)

NAFDAC, established under the *NAFDAC*, is responsible for regulating and controlling the manufacture, importation, exportation, and advertisement of food, drugs, cosmetics,

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[101] Nursing and Midwifery (Registration, etc.) Act, Cap N143, LFN 2004, s. 3.
[102] Ibid s. 5–9.
[103] Pharmacists Council of Nigeria Act, Cap P17, LFN 2004, s. 1.
[104] Ibid s. 6–12.
[105] Counterfeit and Fake Drugs (Miscellaneous Provisions) Act, Cap C34, LFN 2004, s. 1

and medical devices.[106] Although NAFDAC does not discipline practitioners directly, it plays a **preventive role** in the context of medical negligence by ensuring that only **safe and approved drugs** and medical products are available in the Nigerian market. Violations may result in criminal prosecutions or closure of facilities.[107]

NAFDAC's regulatory interventions help mitigate systemic causes of medical negligence, such as substandard medications and unapproved equipment.[108]

### 3.4.5 National Health Insurance Authority (NHIA) and Health Facilities Monitoring Agencies

The **National Health Insurance Authority (NHIA)**, established under the NHIA Act 2022 (formerly NHIS Act 1999), ensures that enrollees receive standard healthcare services from accredited providers.[109]

Under Section 29 of the Act, the NHIA may **investigate complaints** of medical negligence against accredited hospitals and impose administrative sanctions or revoke accreditation.[110]

At the state level, agencies such as the **Lagos State Health Facility Monitoring and Accreditation Agency (HEFAMAA)** perform similar oversight functions by inspecting hospitals, investigating complaints, and closing non-compliant facilities.[111]

## 3.5 JUDICIAL SYSTEM AND REMEDIES AVAILABLE FOR MEDICAL NEGLIGENCE IN NIGERIA

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[106] National Agency for Food and Drug Administration and Control Act, Cap N1, LFN 2004, s. 2.
[107] Ibid s. 5.
[108] AO Oshisanya, 'An Almanac of Contemporary Judicial Restatements (Civil and Criminal Law)' (2nd edn, 2018) 89.
[109] National Health Insurance Authority Act, 2022, s. 29.
[110] Ibid.
[111] Lagos State Health Facility Monitoring and Accreditation Agency Law, 2015, s. 3–5.

The Nigerian judicial system provides both **civil** and **criminal** avenues for addressing medical negligence. The nature of these remedies reflects the constitutional, statutory, and common law traditions inherited from English law, while also integrating professional disciplinary procedures through medical regulatory bodies such as the **Medical and 3.5.1 Dental Council of Nigeria (MDCN)**

**The Role of the Judicial System**

Nigeria's judicial framework for medical negligence is founded primarily upon the **Constitution of the Federal Republic of Nigeria 1999 (as amended)**, which vests judicial powers in the courts established under Sections 6 and 230–296. These include the High Courts, the Court of Appeal, and the Supreme Court, all of which have adjudicatory authority over tortious and contractual disputes arising from health-care delivery.

Medical negligence cases typically fall under **civil jurisdiction**, governed by the **law of tort** and the **law of contract**, depending on the relationship between doctor and patient. Civil liability arises where the patient can prove the **existence of a duty of care**, its **breach**, and the **resulting damage**. This was clearly affirmed in *Dr. Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*, where the Supreme Court underscored the duty of care owed by medical professionals to patients, noting that "a doctor is bound to exercise reasonable skill and care in attending to a patient."[112]

**3.5.1 Civil Remedies Available to Victims**

Victims of medical negligence in Nigeria can seek **civil remedies** in the form of:

**Damages**, to compensate for physical injury, emotional distress, or financial loss;

**Declaratory reliefs**, to affirm the patient's rights or declare the doctor's liability;

**Injunctions**, in rare cases to prevent continuing or future harm;

**Apology or retraction**, though not common, may be ordered by disciplinary bodies.

[112](2001) 7 NWLR (Pt. 711) 206.

In *Ojo v. Gharoro & Ors*, the Supreme Court reiterated that damages in negligence are compensatory, not punitive, and must correspond to the actual harm suffered.[113] Similarly, in *Abatan v. Awudu*, the Court of Appeal upheld damages awarded to a patient who sustained serious complications due to surgical negligence.[114]

The courts have also recognized **vicarious liability**, where hospitals or health institutions may be held responsible for the negligent acts of their employees. This principle was reaffirmed in *Gold v. Essex County Council*, which has influenced Nigerian jurisprudence in holding hospital management accountable.[115]

### 3.5.2 Criminal Remedies and Prosecution

Where negligence crosses into the realm of recklessness or willful disregard for patient safety, **criminal prosecution** may be initiated by the state. The burden of proof lies on the prosecution to establish guilt **beyond reasonable doubt**. Criminal negligence cases are rare in Nigeria but not unprecedented. In *State v. Dr. Ejike Ferdinand Orji*, the doctor was convicted for reckless and negligent treatment leading to deformity of a patient's limb, marking a significant precedent in Nigeria's medical jurisprudence.[116]

### 3.5.3 Professional and Administrative Remedies

Apart from court proceedings, patients may lodge complaints before the **Medical and Dental Practitioners Disciplinary Tribunal (MDPDT)**, established under the **Medical and Dental Practitioners Act Cap. M8 Laws of the Federation of Nigeria 2004**. The Tribunal has powers to investigate allegations of **infamous conduct** and impose sanctions ranging from suspension to permanent deregistration of erring practitioners.

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[113] *Ojo v. Gharoro & Ors* (2006) 10 NWLR (Pt. 987) 173.
[114] (2002) NWLR (Pt. 758) 602.
[115] (1942) 2 KB 293 (CA)
[116] (2023) Unreported, High Court of Lagos State, 19 April 2023.

Furthermore, the **Consumer Protection Council Act 1992** (now incorporated under the Federal Competition and Consumer Protection Act 2019) provides additional remedies for patients as consumers of health-care services. Section 2(2)(a) of the Act empowers the Council to investigate complaints of substandard or injurious medical services.[117]

### 3.5.4 Equitable and Constitutional Remedies

In modern Nigerian jurisprudence, courts have begun to expand remedies through **constitutional interpretation,** linking medical negligence to fundamental rights such as the **right to life** and **right to dignity of the human person** under Sections 33 and 34 of the Constitution. Although this is still developing, cases like *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* suggest that medical negligence may, in extreme cases, implicate constitutional violations.[118]

### 3.5.5 Challenges in Enforcement

Despite the availability of remedies, enforcement remains weak. Litigation is often **slow, costly**, and hindered by **lack of medical evidence or expert witnesses**. The MDPDT also suffers from **bureaucratic delays** and limited public awareness.

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[117] Federal Competition and Consumer Protection Act 2019, s. 2(2)(a).
[118] (2001) 7 NWLR (Pt. 711) 206.

### 3.6 BURDEN OF PROOF IN MEDICAL NEGLIGENCE IN NIGERIA

The burden of proof occupies a central place in medical negligence litigation in Nigeria. Because medical practice is a complex and technical field, the law requires a claimant to establish, by credible evidence, that the health-care provider acted negligently and that such negligence caused the injury suffered. Nigerian courts follow the common-law tradition that **he who asserts must prove**, a rule codified in sections **131–133 of the Evidence Act 2011**. Thus, the **initial burden** lies on the patient (plaintiff) to prove negligence on the balance of probabilities.[119]

**Elements the Plaintiff Must Prove**

To succeed in a claim for medical negligence, the plaintiff must prove the well-established four-prong test:

1. **Existence of a duty of care** between the medical practitioner and the patient.
2. **Breach of that duty** (failure to act with reasonable professional skill).
3. **Causation**, showing that the injury resulted from the doctor's breach.
4. **Damage**, meaning that the plaintiff suffered a legally recognizable injury.[120]

The Supreme Court in ***Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*** reaffirmed that the claimant must demonstrate these elements, and courts will not infer negligence merely because treatment produced an unfortunate outcome.[121]

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[119] Evidence Act 2011, ss 131–133.
[120] Ese Malemi, *Law of Tort* (Princeton Publishing Co., Lagos, 2019) 245.
[121] (2001) 7 NWLR (Pt. 711) 206.

### 3.6.1 Standard of Proof

In civil cases such as medical negligence, the standard is **proof on the balance of probabilities**, meaning the claimant's version must be more likely than not. Nigerian courts apply this standard strictly because negligence is a **question of fact**, not suspicion.[122]

It has been reiterated that a plaintiff must tender **credible and cogent evidence**, often including medical records or expert testimony, to demonstrate breach and causation.

### 3.6.2 Role of Expert Evidence

Because medical issues are highly technical, courts generally require **expert testimony** to establish whether the defendant acted according to accepted medical standards. This principle is derived from the English case ***Bolam v. Friern Hospital Management Committee***, which has been fully adopted in Nigeria. It has been emphasized that judges are not medically trained and must rely on expert opinion to determine whether professional skill fell below standard.

However, expert evidence is not indispensable in all cases. Where negligence is so obvious that a layperson can infer it such as leaving a surgical instrument in a patient's abdomen—the doctrine of ***res ipsa loquitur*** may apply.

### 3.6.3 Application of *Res Ipsa Loquitur*

Although Nigerian courts apply *res ipsa loquitur* cautiously, they accept it in situations where the injury would not ordinarily occur without negligence. In ***Ibrahim v. Nigerian Army***, the Court held that the doctrine may be invoked where:

the event is such that it ordinarily does not happen without negligence;

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[122] (1978) 4 SC 91.

the instrumentality causing harm was under the defendant's control; and

the plaintiff had no contributory role.[123]

When applicable, *res ipsa loquitur* shifts **evidential burden** to the defendant, who must then explain that the injury was not due to negligence. The legal duty to prove negligence **remains with the plaintiff**, but the defendant must rebut the presumption of fault.

### 3.6.4 Proving Causation

Causation is often the **most difficult** aspect of medical negligence litigation. Nigerian courts insist on a clear, logical connection between the breach and the harm. In ***University of Ilorin Teaching Hospital v. Abegunde***, the Court held that the plaintiff must show not only that the defendant breached a duty but that the breach **materially contributed** to the injury.[124]

Where multiple factors may have caused the injury, courts require proof that the defendant's conduct was a **substantial factor**. This aligns with the "but for" test from common law: but for the defendant's breach, the injury would not have occurred.

### 3.6.5 Burden on the Defendant

Once the plaintiff establishes a prima facie case:

The **evidential burden shifts to the defendant** to show that they acted with reasonable care or that the injury was not caused by negligence;

The doctor may defend themselves by showing adherence to accepted medical practice (Bolam defence);

They may also rely on contributory negligence or voluntary assumption of risk.

But the primary legal burden **never leaves** the plaintiff.

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[123] (2015) 6 NWLR (Pt. 1454) 372.
[124] (2012) 43 E-WRN / 59 (CA)

### 3.6.6 Standard of Proof in Medical Negligence Cases in Nigeria

The standard of proof in medical negligence cases is the **civil standard** proof on a **balance of probabilities.** This means that the plaintiff must demonstrate that it is more likely than not that the medical practitioner acted negligently and that such negligence caused the injury.[125] This standard is derived from civil jurisprudence and codified in **sections 131–134 of the Evidence Act 2011**, which govern the burden and standard of proof in civil proceedings.[126]

Nigerian courts have consistently applied this standard even in matters involving highly technical evidence. In ***Ojo v. Gharoro***, the Supreme Court held that despite the complexities inherent in medical science, "the plaintiff bears the onus of establishing negligence by credible, preponderant evidence."[127] The Court stressed that judges must rely on expert testimony where medical questions exceed ordinary knowledge.

However, where allegations contain elements of **crime** e.g., gross malpractice, falsification of medical records, or unlawful abortion the standard of proof becomes **beyond reasonable doubt**, pursuant to section 135 of the Evidence Act.[128] Thus, medical negligence may involve **dual standards of proof**, depending on whether the alleged conduct also constitutes a criminal offence.

### 3.6.7 Challenges in Proving Medical Negligence in Nigeria

Litigants face several systemic and evidentiary obstacles in establishing medical negligence in Nigeria:

1. Limited Access to Medical Records

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[125] (2001) 7 NWLR (Pt. 711) 206.
[126] Evidence Act 2011, ss 131–134.
[127] (2006) 10 NWLR (Pt. 987) 173.
[128] Evidence Act 2011, s 135.

Medical records are vital for proving breach and causation. Yet, many hospitals especially public ones maintain poor records or refuse to release them. In ***University of Ilorin Teaching Hospital v. Abegunde***, the Court criticized the hospital for inadequate documentation that hindered the claimant's proof.[129]

2. Difficulty in Obtaining Expert Evidence

Given the professional fraternity among medical practitioners, securing expert testimony against colleagues is difficult. Courts have lamented this challenge, noting that the absence of expert opinion often weakens plaintiffs' claims.[130]

3. Technical Complexity

The subject matter of medical negligence is highly specialized. Plaintiffs often lack resources to produce the necessary technical evidence to demonstrate breach. Judges, not being medical professionals, may be reluctant to infer negligence without explicit expert explanation.

4. Judicial Deference to Medical Judgment

Nigerian courts, following the Bolam test, defer to "a responsible body of medical opinion." This deference can tilt the evidential burden toward the patient.[131]

5. Financial and Procedural Constraints

Medical negligence litigation is expensive, lengthy, and uncertain. The absence of legal aid and the high cost of hiring experts further discourage claimants.

**Burden of Proof Before Medical Disciplinary Tribunals (MDPDT)**

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[129] (2012) 43 E-WRN / 59 (CA)
[130] Ese Malemi, (n45)
[131] ***Bolam v. Friern Hospital Management Committee*** [1957] 1 WLR 582.

The **Medical and Dental Practitioners Disciplinary Tribunal (MDPDT)** hears cases of misconduct. Proceedings are **quasi-criminal**, and the standard of proof is **beyond reasonable doubt**.[132]

However, the **evidential rules are more flexible** than in regular courts:

The Tribunal may rely on documentary materials, testimonies, and investigative reports.

The Tribunal can admit evidence that may not ordinarily be admissible under the Evidence Act.

Once the MDCN establishes a prima facie case, the practitioner must rebut it by demonstrating adherence to acceptable medical standards.

Thus, while the **legal burden** remains with the MDCN, the **evidential burden** may shift to the practitioner depending on the facts.

**3.7 Conclusion**

The burden of proof in medical negligence cases constitutes one of the most critical determinants of success or failure in patient-initiated litigation within the Nigerian legal system. Through judicial decisions, statutory provisions, and doctrinal authority, it is clear that the law imposes a stringent evidential responsibility on the patient, who must establish duty, breach, causation, and damage on the **balance of probabilities**. Although this standard aligns with general civil jurisprudence, the complexity of medical practice frequently places litigants at a disadvantage, as they must marshal technical and expert-driven evidence that is often costly, inaccessible, or withheld by healthcare institutions.

Nigerian courts have consistently maintained the traditional Bolam-based professional standard, requiring claimants to demonstrate that the practitioner acted in a manner

[132] Medical and Dental Practitioners Act Cap M8 LFN 2004, s 16.

inconsistent with accepted medical practice. This approach, while rooted in respect for medical expertise, has contributed to the high evidential threshold patients must overcome. The limited adoption of more progressive judicial tests such as the Bolitho "logical basis" refinement—further underscores the conservatism of Nigeria's courts in scrutinizing clinical judgment. As a result, medical practitioners benefit from wide judicial deference, while patients face an uphill task in proving negligence.

The challenges are not merely doctrinal but systemic. Poor medical record-keeping, reluctance among doctors to testify against colleagues, financial constraints, and limited public awareness of patient rights all complicate the evidential burden. Although mechanisms such as the Medical and Dental Practitioners Disciplinary Tribunal (MDPDT) and the Federal Competition and Consumer Protection Act (FCCPA) 2019 offer alternative avenues for redress, these bodies also impose significant evidential obligations sometimes even the criminal standard of proof when allegations involve professional misconduct or malpractice with criminal elements.

Comparative insights from other jurisdictions reveal that Nigeria's framework is still developing. Countries such as the United Kingdom, United States, India, and South Africa have embraced more patient-centric doctrines, enhanced access to medical records, and strengthened procedural tools such as discovery. Nigerian law, by contrast, retains a largely traditional approach that prioritizes professional autonomy over patient protection.

In conclusion, while the foundational principles governing the burden of proof in medical negligence are conceptually sound, their practical application significantly disadvantages plaintiffs. A balanced model one that preserves professional discretion while enhancing patient access to evidence, encouraging expert neutrality, improving hospital

documentation, and adopting modern judicial tests would better reflect the evolving realities of healthcare and the constitutional recognition of the right to health. Strengthening these aspects is essential for creating a fairer, more responsive system of accountability and for ensuring that victims of medical negligence in Nigeria can obtain meaningful remedies.

# CHAPTER FOUR

# LEGAL LESSONS FROM INTERNATIONAL STANDARDS AND OTHER JURISDICTIONS

## 4.1 INTRODUCTION

The regulation of medical negligence has increasingly assumed an international and comparative dimension, as healthcare delivery across jurisdictions is guided byshared professional standards, human rights norms, and evolving judicial approaches. In Nigeria, the challenges associated with medical negligence, including weak enforcement mechanisms, evidentiary difficulties, and limited patient awareness, have necessitated a critical examination of how other legal systems respond to similar concerns. Comparative legal analysis therefore offers an important framework for identifying best practices and adapting tested solutions to Nigeria's medico-legal environment. International standards developed by global health and human rights institutions have laid a foundational framework for patient safety and quality healthcare. These standards emphasize accountability, transparency, and respect for patient autonomy, thereby influencing national laws and judicial reasoning in many jurisdictions. Beyond these global norms, countries such as the United Kingdom, the United States, South Africa, and Ghana have

developed distinct but instructive approaches to medical negligence, particularly in relation to informed consent, standards of professional care, and procedural safeguards in malpractice litigation. This chapter examines the legal lessons Nigeria can draw from international standards and the jurisprudence of selected foreign jurisdictions. By analysing how courts and regulatory systems in these jurisdictions address medical negligence and balance the competing interests of patients and healthcare practitioners, this chapter seeks to identify principles capable of strengthening Nigeria's legal response to medical malpractice. Ultimately, the comparative insights discussed herein provide a basis for reform-oriented recommendations aimed at improving patient protection, enhancing professional accountability, and promoting a safer and more reliable healthcare system in Nigeria.

## 4.2 COMPARATIVE ANALYSIS WITH INTERNATIONAL STANDARD

Medical negligence have become central issues in global healthcare law. While Nigerian jurisprudence draws heavily from English common law, international standards particularly those from the United Kingdom, United States, and the World Health Organization (WHO) have evolved to prioritize patient safety, autonomy, and systemic accountability. This chapter undertakes a comparative analysis of Nigerian legal principles with international norms, highlighting areas of convergence and divergence, and offering insights into how Nigeria's medical liability regime can be strengthened.

### 4.2.1THE STANDARD OF CARE: THE BOLAM TEST EVOLUTION.

The most influential test for determining medical negligence remains the Bolam Test, established in *Bolam v. Friern Hospital Management Committee*[133]. The English court held that a doctor is not negligent if his conduct conforms to a practice accepted as proper by a responsible body of medical opinion skilled in that particular art. This professional standard has guided Nigerian courts for decades. It was this approach that was adopted by the Supreme Court in *Ojo v. Gharoro & Ors*[134], wherein the court insisted that expert testimony was fundamental and intrinsic to establishing whether or not a practitioner acted within accepted medical standards. The Bolam test has been criticized internationally for its undue deference to the medical profession, at the expense of patient autonomy and accountability.

This major shift occurred with the decision of the UK Supreme Court in *Montgomery v. Lanarkshire Health Board*[135], which for the first time redefined the doctor's duty from a professional-centered to a patient-centered perspective. The Court held that a doctor must take reasonable care to ensure that the patient is aware of any material risks involved in treatment, as well as reasonable alternatives. The Montgomery decision marked a

[133] (1957) 1 WLR 582.
[134] (2006) 10 NWLR (Pt. 987) 173.
[135] [2015] UKSC 11

paradigm shift-from what doctors consider appropriate to what a reasonable patient would want to know.

**4.2.2COMPARATIVE IMPLICATION FOR NIGERIA:**

While Nigerian courts remain loyal to the Bolam standard, there is beginning to emerge recognition of patient rights and autonomy. Thus, in *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal*[136], the Supreme Court upheld the right of a Jehovah's Witness to refuse blood transfusion, reiterating that patient autonomy is part of the canon of medical ethics. This represents developing coherence of Nigerian law with evolving international standards emphasizing informed consent and human dignity.

**4.2.3 INFORMED CONSENT: FROM PROFESSIONAL JUDGMENT TO PATIENT AUTONOMY**

The United States pioneered the shift toward patient-centered care *in Canterbury v Spence*[137] where the court held that the duty to disclose risks is measured by what a reasonable patient would consider material to their decision, not by what the medical profession deems appropriate.

Similarly, the Montgomery case in the UK (2015) extended this reasoning, rejecting the Bolam test in the context of informed consent. It held that doctors must communicate material risks in a manner comprehensible to the patient.[138]

Informed consent standards, on the other hand, have not been clearly codified in Nigeria but has hitherto rested on professional custom and ethical guidelines issued by the MDCN. While courts have often required evidence of negligence through expert testimony, as was made in the case of *Ojo v. Gharoro*, they have fallen short of embracing a patient-centered disclosure test. The recognition of autonomy in Okonkwo thus far represents a move in that direction, but a more overt doctrinal shift is needed to bring the Nigerian judiciary into line with the Montgomery and Canterbury standards.[139]

**4.2.4 SYSTEMIC ACCOUNTABILITY AND PATIENT SAFETY: THE W.H.O GLOBAL STANDARD**

Internationally, modern health law is increasingly focused on systemic safety rather than individual blame. The WHO, through its Global Patient Safety Action Plan 2021–2030, calls upon member states to put in place comprehensive patient safety systems that ensure learning, transparency, and non-punitive reporting mechanisms.[140]

These frameworks advocate a "just culture" that encourages healthcare professionals to promptly report such errors without any fear of punitive sanctions, so that the institutions

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[136] (2001) 7 NWLR (Pt. 711) 206.
[137] 464 F.2d 772 (D.C. Cir. 1972).
[138] *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11
[139] Ese Malemi, (n45)
[140] World Health Organization, *Global Patient Safety Action Plan 2021–2030* (WHO, 2021) <https://www.who.int/teams/integrated-health-services/patient-safety/policy/global-patient-safety-action-plan> accessed 23rd November 2025

can identify and rectify the systemic failures. This is apparently a departure from traditional tort-focused models, which emphasize compensation rather than prevention.
The current framework in Nigeria is predominantly oriented toward individual liability through tort and professional disciplinary mechanisms under the Medical and Dental Practitioners Act.[141] Little institutional accountability exists or national strategy for patient safety. Incorporating WHO's standards in health governance in Nigeria, such as incident reporting, root-cause analysis, and public safety audits, would enhance preventive measures to avoid repeated incidents of negligence.

### 4.2.5 COMPARATIVE INSIGHTS FROM OTHER AFRICAN COUNTRIES

Comparative law offers useful perspectives for Nigeria's ongoing struggle with medical negligence. Some African countries have adopted reforms, produced significant judgments, or implemented national reporting frameworks that Nigeria can study. The discussion below highlights key developments in **South Africa, Kenya, Ghana, Egypt**, and regional/WHO patient-safety initiatives, and draws lessons for Nigerian law and policy.

1. **South Africa** — formal reporting systems, high claim volumes, institutional learning

South Africa has a developed body of medical-negligence jurisprudence and an established **national guideline for patient-safety incident reporting and learning** (first issued 2018; updated version 2022). The guideline sets out a national web-based Patient Safety Incident Reporting & Learning System, a classification scheme for incidents, and a "just culture" approach to encourage reporting and root-cause analysis.[142] Empirically, South Africa has experienced large and growing claims (both number and value), particularly in maternal health, surgical complications and misdiagnosis; commentators warn of a "medical-negligence crisis" driven partly by under-resourced public facilities

[141] Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004
[142] **National Guideline for Patient Safety Incident Reporting and Learning in the Health Sector of South Africa — Version 2 (2022),** National Department of Health (RSA).

and litigable harm.[143] South African jurisprudence also reinforces institutional (vicarious) liability of hospitals and the centrality of expert medical evidence in establishing the standard of care (see leading cases summarized by South African legal practitioners).[144]

**Lessons for Nigeria:**

A **national reporting and learning framework** used for system-wide learning rather than only for punishment can improve safety and reduce repeat events. The South African guideline is a model for Nigeria's health ministry to adapt.

Strengthening incident classification, outcome metrics, and protected reporting reduces under-reporting and fosters a "just culture."

2. **Ghana** — growing litigation, doctrinal caution, and calls for specialized mechanisms

Ghanaian scholarship and case-law reviews show an **increasing number of medical-negligence claims** and a doctrinal pattern resembling Nigeria's: courts insist on expert evidence, treat *res ipsa loquitur* cautiously, and frequently focus on procedural proof rather than automatic liability. Empirical work surveying Ghanaian malpractice litigation finds complexity in access to proof and a slow but visible willingness of claimants to litigate against both public and private providers.[145] Legal commentators in Ghana have proposed a specialised medico-legal tribunal or streamlined procedures to make claims less costly and more technically supported.[146]

**Lessons for Nigeria:**

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[143] **South Africa's medical-negligence crisis — analysis**, Think Global Health (3 October 2024).
[144] **Medical negligence case law in South Africa — practitioner summary**, PM Attorneys (case summaries)
[145] J **Bayuo and A Koduah, 'Pattern and outcomes of medical malpractice cases in Ghana: A Systematic Content Analysis'** ***Ghana Medical Journal*** **(2022)**
[146] J Zutah and others, **'Licensed to kill? Contextualising medical misconduct in Ghana'** ***UCC Law Journal*** **(2021) 1 (2) 49-118 <https//journal.ucc.edu.gh> accessed 24th November 2025.**

Ghana's experience reinforces the need for **procedural innovation** specialised tribunals or court-appointed expert panels to reduce the evidential and cost barrier to justice.

Empirical monitoring of case outcomes helps identify systemic hotspots (e.g., obstetrics, surgery) for targeted safety interventions.

Comparative experience shows a **blend of regulation, reporting, judicial relief and statutory clarity** produces the best balance between accountability and patient safety. South Africa's national reporting guideline on liability are particularly instructive for Nigeria: combine **systemic learning (protected reporting + national data)** with **clear legal thresholds** for criminal prosecution, and **procedural reforms** (special tribunals or court-appointed experts) to make civil redress accessible. Implementing these measures in a federated manner that respects Nigeria's state-level health responsibilities will be crucial.

### 4.3 CONCLUSION

This chapter reviewed comparative international standards, revealing that jurisdictions such as the Ghana, and South Africa have adopted proactive measures including mandatory professional indemnity insurance, specialised medical negligence tribunals, electronic medical record systems, and streamlined patient-complaint mechanisms. These models highlight the importance of accessible remedies, strong regulatory institutions, and continuous professional development in safeguarding patient welfare. Nigeria's deviation from these standards underscores the need for deliberate and strategic reforms tailored to the country's socio-legal context.

# CHAPTER FIVE

# SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUTION

## 5.1 SUMMARY OF FINDINGS

Nigeria's regime for medical negligence is built on a mix of inherited common law, local statutes, and constitutional guarantees. By law, medical negligence is treated as an ordinary tort: a doctor owes a duty of care once he or she undertakes treatment, and must meet the standard of a reasonably competent practitioner. Courts apply the English-based Bolam test: for example, in *Ojo v. Gharoro & Ors* the Supreme Court held that a surgical misShap (a broken needle) by itself does not establish negligence; instead, the patient must show through expert proof that the doctor's care fell below accepted professional standards. In practice the patient-plaintiff bears the burden to prove duty, breach, causation and harm on the balance of probabilities, as codified in the Evidence Act. The Act's Section 134 explicitly places this onus on the claimant, with civil proof ("more likely than not") the default standard. This tort framework is bolstered by statutes: the

Medical and Dental Practitioners Act establishes the Medical and Dental Council of Nigeria (MDCN) and its Disciplinary Tribunal to regulate doctors' conduct, and the National Health Act (2014) formalizes patient rights like informed consent and quality of care. Even the new Federal Competition and Consumer Protection Act (2018) classifies patients as consumers of healthcare. Above all, Nigeria's Constitution underpins these duties: rights to life, dignity, personal liberty and privacy impose ethical and legal obligations on medical providers. Section 33's guarantee of life means healthcare workers and the State must avoid unjust deprivation of life. Similarly, the rights to dignity and freedom of conscience require that patients be treated humanely and allowed to make informed choices. Although Nigeria has no express justiciable "right to health," courts and scholars increasingly interpret life and dignity provisions as grounding health rights and requiring the State to provide adequate care. In sum, Nigeria's substantive law blends traditional tort principles with health-specific statutes and constitutional values to define medical malpractice.

Nigerian case law vividly illustrates how these standards are applied. The courts consistently demand clear proof of substandard care. In *Medical & Dental Practitioners Disciplinary Tribunal v. Okonkwo* (the "Jehovah's Witness" case), for instance, the Supreme Court clarified that a doctor is not negligent for respecting a patient's informed refusal of blood if he obtained and documented that consent. This case reaffirmed that liability hinges on a breach of duty, not on moral judgment, and highlighted patient autonomy under the law. Conversely, *Ojo v. Gharoro & Ors* shows the courts' insistence on evidence: Mrs. Ojo's claim (that a needle was left in her body) failed because the Supreme Court held that an "abnormality per se" does not prove negligence without

expert testimony on breach and causation. Similarly, *Abatan v. Awudu* (a Court of Appeal case) underlines hospital liability: the court confirmed that hospitals can be vicariously liable for staff negligence and that damages must be compensatory, based on the injury caused. On the criminal side, Nigerian law recognizes gross negligence as manslaughter: in *State v. Orji*, a Lagos case, a doctor was actually convicted of reckless and negligent treatment that maimed a patient.

Notably, courts draw a line between mere mistake and culpable conduct. In *Okonkwo v. MDPDT* the Supreme Court distinguished simple negligence (civilly actionable) from gross misconduct (punishable under the statutory disciplinary tribunal). The doctrine of res ipsa loquitur (letting the fact of a normally absent event speak for negligence) is recognized but used sparingly. In all these cases, Nigerian judges emphasize that doctors need only meet the standard of a reasonably competent peer, not perfection. The net effect is that plaintiffs must meet a demanding proof threshold – bolstered by expert testimony – to show a breach of care that legally caused injury.

Despite this elaborate legal framework, patients face profound procedural and evidentiary hurdles in practice. The primary challenge is proving a technical claim in court. Because medical issues are highly specialized, courts routinely require credible medical evidence at trial. Plaintiffs usually need to produce expert witnesses to show how the doctor deviated from accepted practice. Yet obtaining unbiased experts is extremely difficult: many doctors are reluctant to testify against colleagues, and the professional fraternity is tight-knit. At the same time, crucial medical records are often incomplete or withheld. Nigerian hospitals – especially public ones – frequently keep poor records or cite privacy to resist disclosure, hampering proof of what actually happened. This means plaintiffs

may not even know the full facts of their treatment. Litigation itself is also onerous. Malpractice claims proceed in the regular courts, which are slow and expensive. There is no specialized tribunal or discovery process. Consequently, many patients either cannot afford the process or cannot sustain a multi-year battle to gather evidence.

The standard of proof adds another layer of difficulty. Civil negligence claims must meet the usual balance-of-probabilities test, but if allegations touch on criminal misconduct (e.g. unauthorized abortion, gross malpractice), the Evidence Act requires proof beyond reasonable doubt. In practice this mixed standard means that any hint of willful wrongdoing raises the bar even higher. Nigerian courts have also been wary of broadly applying the res ipsa doctrine: they use it only when a normal outcome could not occur without negligence. Thus, even in clearly botched cases patients often must painstakingly reconstruct the chain of events through experts. Socio-economic and cultural factors compound the problem. Many Nigerians are unaware of their rights or of recourse under the new Patients' Bill of Rights and consumer laws. Fatalism, fear of stigma, or trust in traditional remedies may discourage formal claims. Overall, the combination of these evidentiary and procedural obstacles means that only a small fraction of harmed patients achieve redress. As one analysis bluntly concludes, the strict burdens enshrined in law "significantly disadvantage plaintiffs" and effectively privilege medical professionals' discretion.

Finally, regulatory bodies like the MDCN play a complementary role but with clear limits. By statute, the MDCN is charged with licensing practitioners, maintaining standards, and disciplining errant doctors. Its Disciplinary Tribunal (MDPDT) can try physicians for "infamous conduct in a professional respect" – a term that includes gross negligence or

ethical breaches. In *MDCN v. Okonkwo*, the Supreme Court affirmed the Tribunal's authority and underscored that its actions must respect patients' constitutional rights. However, critics note that the MDCN's regulatory apparatus is chronically under-funded and slow. One report describes its mechanisms as "under-resourced and slow," with protracted timelines that often discourage complainants. Moreover, the MDCN's role is solely disciplinary: it can revoke licenses but cannot award compensation. Patients, therefore, must still sue in court for damages. Other bodies (such as the Nursing Council, Pharmacists Council, NAFDAC, etc.) address sector-specific lapses, but they too face similar capacity constraints. Even the new Health Ombudsman office created by the National Health Act has yet to become an effective venue for grievances.

In summary, Nigeria's laws on medical negligence are, on paper, comprehensive: they articulate clear tort duties, embed patient protections in statute, and root healthcare within constitutional rights. Courts have detailed how these rules apply, from the Bolam-based standard of care to the necessity of consent and the possibility of criminal manslaughter for gross errors. Yet the real-world impact has been muted by systemic issues. Plaintiffs face a "stringent evidential responsibility" and heavy hurdles at every turn. Regulatory institutions exist but operate with limited reach. The analysis concludes that without reforms – faster procedures, better funding for oversight, and greater public awareness – many legitimate claims will continue to falter despite the law's detailed protections.

**5.2 RECOMMENDATIONS AND CONCLUISON**

The research reveals that Nigeria's approach to medical negligence is firmly grounded in traditional tort principles but faces significant practical hurdles. Courts consistently apply the duty-of-care test inherited from English common law: a doctor must exercise the skill

and care of a reasonably competent practitioner in the same field. For example, in *Ojo v. Gharoro* the Supreme Court held that a poor surgical outcome does not by itself prove negligence; the claimant must prove that the physician failed to exercise the ordinary skill of his profession. Likewise, *Okonkwo v. MDPDT* affirmed that physicians cannot be faulted for respecting a patient's informed refusal, underscoring that liability rests on breach of duty, not on moral judgment. In sum, the law requires every element of negligence – duty, breach, causation, and damage – to be cumulatively established. On paper, this framework is supported by a solid body of statute and case law: the Constitution (rights to life and dignity), the National Health Act 2014, and the Medical and Dental Practitioners Act collectively enshrine patients' rights and set professional standards. The Medical and Dental Practitioners Act specifically empowers the Medical and Dental Council of Nigeria (MDCN) and its tribunal to sanction "infamous conduct," including gross negligence. Consumer-protection law also offers recourse, treating patients as consumers entitled to safe services.

Despite this comprehensive legal structure, the findings show that statutory and case law obligations often fail to reach injured patients. The burden of proof in Nigeria rests firmly on the patient. By statute, a claimant must prove negligence "on the balance of probabilities". Courts apply this civil standard strictly: treatment that results in harm is not enough; the patient must present credible evidence that the doctor departed from the accepted standard. Because medical facts are technical, Nigerian courts generally require expert testimony to demonstrate breach of care and causation. Only in rare, obvious cases – for instance, a surgical instrument left inside a patient – can the doctrine of *res ipsa loquitur* shift a presumption of fault onto the doctor. Even then, the defendant can rebut

that presumption, and the formal legal burden never departs from the plaintiff. The study notes that in practice this evidentiary regime heavily favors defendants. Many claimants lack access to medical records or cannot afford expert witnesses, making it difficult to meet the court's demanding proof requirements. In cases blending malpractice with criminal conduct (such as unauthorized abortion or record falsification), the law even requires proof beyond reasonable doubt, adding yet another hurdle.

Analysis of case law illuminates these patterns. In the landmark *Ojo* case, the Supreme Court carefully reviewed a broken needle left in a patient's abdomen. Although the fact pattern seemed negligent, the court refused to award damages because the plaintiff failed to present expert evidence showing how the needle broke – the basic elements of breach and causation were not established. This ruling underscores that Nigerian courts will not presume error; plaintiffs must mount a detailed, technical case. Conversely, recent high-profile cases demonstrate the system's limits and possibilities. The *State v. Orji* criminal trial convicted an orthopedic doctor for gross negligence that injured a child, imposing a prison sentence. This judgment is novel: it shows that extreme professional failures can attract criminal sanctions in Nigeria and signals the seriousness with which courts may treat reckless medical conduct. For instance, the coroner's inquest into Mrs. Peju Ugboma's avoidable death in 2021 openly found gross failures by a private hospital, but by law the coroner could not award damages. Such cases highlight the paradox that public condemnation or regulatory action may follow tragedy, but the formal legal remedies remain elusive.

The institutional framework offers channels for accountability, but their impact is undermined in practice. The MDCN and its disciplinary processes exist in statutory form,

and the 2008 Code of Medical Ethics spells out doctors' duties (consent, confidentiality, etc.). In recent years the MDCN has indeed deregistered or suspended erring doctors, demonstrating the possibility of non-litigious discipline. However, the research finds that regulatory bodies suffer from chronic under-resourcing and procedural delays. Complaints can languish for years, and the public is often unaware of the processes or outcomes. The Patients' Bill of Rights under the National Health Act is weakly enforced, and the proposed ombudsman office remains largely inactive. In short, although a comprehensive system of professional and institutional safeguards exists on paper, its real-world efficacy is limited.

Across these findings, a consistent theme is the severe difficulty faced by patients seeking redress. Many Nigerians simply do not know their legal options, especially outside major cities. Cultural factors also play a role; patients often defer to medical authority and may not question substandard care. When claims are pursued, economic barriers loom large. High court fees, lawyers' costs, and the need to hire specialists create prohibitive expenses. Court backlogs can delay justice for years, by which time both evidence and political will may have dissipated. These challenges contribute to inequality: affluent families or those in urban centers are far more likely to obtain expert help, while the poor and rural sick may never see their grievances heard. This landscape means that even though Nigeria's laws articulate patients' rights (including to quality care and informed consent), there remains a large gap between legal theory and patient experience.

In light of these issues, the study offers a range of practical recommendations to strengthen patient protection, clarify legal standards, and enhance accountability. **Judicial and Procedural Reforms:** The creation of specialized medical-judicial tribunals or fast-

track procedures is strongly urged. Such bodies – staffed by legally trained judges and medical experts – could manage complex evidence more effectively and reduce costs and delays. Procedural innovations might include court-appointed experts or subsidized expert testimony to ease the claimant's burden. Regular training for judges on medical issues would also improve the quality of adjudication. Additionally, harmonizing civil and criminal standards through clear statutes is recommended. For example, legislation should specify when negligent care rises to criminal recklessness, to resolve uncertainties highlighted by the Orji appeal.

**Legislative and Policy Changes:** The research identifies a need for explicit statutory guidance on patient rights. A well-publicized Patients' Bill of Rights, grounded in the National Health Act, should be developed and enforced. Key elements such as informed consent, right to information, and emergency care obligations must be spelled out and backed by enforcement mechanisms. On the enforcement side, mandatory professional indemnity insurance for doctors is advised, ensuring that compensation is available to victims without years of litigation. Laws should also facilitate incident reporting and learning: for instance, a national system for non-punitive reporting of medical errors (modeled on international best practices) could help identify risks and prevent harm.

**Strengthening Regulatory Institutions:** The MDCN and related agencies must be bolstered to make discipline meaningful. Budgetary and human resources should be allocated so that complaints are investigated promptly and transparently. Statutory timelines for MDCN proceedings, along with public reporting of enforcement actions, would increase accountability and public confidence. The Council's outreach should be expanded so that patients and doctors alike are aware of ethical standards and complaint

procedures. Similarly, coroners' courts and ombudsman offices – which today can only issue recommendations – should be empowered to impose at least limited remedies or refer cases for prosecution, closing the enforcement gap seen in cases like the Ugboma inquest.

**Public Awareness and Education:** Finally, raising awareness is critical. Healthcare facilities and civil society should undertake outreach to inform Nigerians of their healthcare rights and the importance of documenting care. Doctors should be trained and reminded of their legal duties – including obtaining proper informed consent – as part of continuing education. The study emphasizes that greater transparency (for example, publicizing tribunal decisions and patient-feedback mechanisms) will reinforce a culture of safety.

In conclusion, this study shows that Nigeria has developed a robust legal framework for medical negligence in alignment with constitutional and international norms. Yet the findings make clear that substantive legal standards alone are insufficient. Without systemic reform, procedural complexity, cost, and institutional deficiencies will continue to frustrate patients' ability to obtain justice. The recommendations offered here are intended to bridge that gap. Given the vital role of healthcare in protecting life and dignity, the need for reform is urgent. Strengthening medical-legal accountability will not only improve outcomes for injured patients, but will also bolster public trust in Nigeria's healthcare system. The stakes – for individual victims and for societal well-being – could hardly be higher, and timely action could prevent much needless suffering in the future.