# Assessment of the Gaps Between Legal Provisions, Knowledge, and Implementation of Medical Negligence Laws in Nigeria

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## Abstract

Medical negligence is a breach of the duty of care by healthcare providers causing patient harm. It constitutes a significant but under-explored issue in Nigeria. This research examines the *gaps* between the laws on medical negligence, public and professional awareness of these laws, and their practical enforcement. The study aims to assess how well existing legal provisions protect patients and hold practitioners accountable, and to identify why most victims often fail to obtain redress. Both doctrinal and non-doctrinal methodology is adopted, combining analysis of statutes and case law with qualitative data. The paper reviews empirical literature on Nigeria, outlines key theoretical foundations of negligence and surveys relevant legislation and case law. Findings suggest that although Nigeria's tort law theoretically governs medical negligence, there are critical gaps in awareness and enforcement. For example, many patients are unaware of their rights and how to sue, and doctors often lack indemnity cover or medicolegal training. Socio-cultural factors (fatalism, trust, cost) and systemic barriers (fragmented laws, evidentiary hurdles) further limit litigation. The paper concludes with recommendations to bridge these gaps: raising legal and rights awareness, enhancing medicolegal education, mandating professional indemnity insurance, and reforming procedural laws (evidence rules) to facilitate claims.

## Literature Review

Recent empirical studies highlight multiple dimensions of medical negligence in Nigeria. Patient surveys show widespread frustration with medical errors but low litigation rates. For instance, a hospital-based study found that 64.5% of patients were annoyed by errors, and 88.5% said the *severity* of an error or perception of negligence would motivate them to sue[1]. Voluntary disclosure by doctors actually *reduced* patients' intent to litigate. Similarly, Madan et al. report that severity

[1] Maxwell C. Opara, *Legal Framework for Proof of Medical Negligence in Nigeria* (2025) 19(3) AJARR 20–32.

of harm and belief that negligence occurred are the main triggers for litigation intent. In practice, however, very few cases reach court[2]. Among 145 Nigerian physicians surveyed, 42.8% admitted committing a medical error; yet *none* of those cases resulted in any lawsuit[3]. All errant doctors hid errors from patients, and about one-third of those who erred suffered depression over it. This suggests a profound disconnect between the frequency of errors and the volume of claims.

Studies of healthcare professionals confirm low awareness of legal protections. In a Lagos survey, most doctors were unaware of professional indemnity insurance and rarely obtained it[4]. The authors argue this stems from a wider culture: victims of malpractice in Nigeria often do *not* sue due to illiteracy, religious beliefs, and poverty. Another analysis notes that many Nigerian patients suffer negligence from underfunded hospitals and inexperienced staff, yet "few cases of medical negligence are reported[5]". Leon's review identifies *poor awareness* of rights, the high cost and complexity of litigation, and even religious fatalism as chief obstacles[6]. These obstacles are compounded by judicial factors.

Legal scholars and clinicians have also examined the issue. Obaro emphasizes that *neither* victims nor many doctors understand their legal rights or liabilities in Nigeria[7]. He notes that many patients do not know how to seek redress, and practitioners often lack awareness of medicolegal obligations. A human-rights perspective further highlights the gap. Michael finds a "striking gap between frequent incidents of negligence and the low volume of reported cases," attributing it to cultural fatalism, inaccessibility of courts, and lack of patient-rights awareness[8]. Likewise, Odunsi observes that cultural, religious and social norms in Nigeria have historically deterred medical negligence claims, though globalization and social media may be shifting this trend[9].

In sum, empirical findings paint a consistent picture: medical errors are common, but litigation is rare. Contributing factors include knowledge gaps; patients unaware of rights; doctors unaware of

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[2] Madan R, Das N, Patley R, Nagpal N, Malik Y, Math SB. Consequences of medical negligence and litigations on health care providers - A narrative review. Indian J Psychiatry. 2024 Apr;66(4):317-325. doi: 10.4103/indianjpsychiatry.indianjpsychiatry_799_23. Epub 2024 Apr 22. PMID: 38778854; PMCID: PMC11107921.

[3] Iloh, Gabriel Uche Pascal; Chuku, Abali; Amadi, Agwu Nkwa. Medical Errors in Nigeria: A Cross-sectional Study of Medical Practitioners in Abia State. Archives of Medicine and Health Sciences 5(1):p 44-49, Jan–Jun 2017. | DOI: 10.4103/amhs.amhs_1_17

[4] Ajemunigbohun, Aduloju &Toyin, Awareness and Patronage of Healthcare Professional Indemnity Insurance: Empirical Evidence among Medical Practitioners in Lagos, Nigeria (2023) . ttps://dj.univ-danubius.ro/index.php/AUDOE/article/view/378/991

[5] Duruiheoma, The Victim-Patient's Search for Redress: Evaluating Responses to Patient Safety Incidents in Nigeria. https://harvest.usask.ca/server/api/core/bitstreams/34111611-db6e-44b7-bb09-875716e6ed7c/content

[6] Leon Green, Identif ication of Issues in Negligence Cases, 26 SW L.J. 811 (1972) https://scholar.smu.edu/smulr/vol26/iss5/1

[7] H. K. Obaro, "Legal Imperatives of Medical Negligence and Medical Malpractice" (2022) *Nigerian J of Medicine* 31(5):598–603

[8] O.D. Michael, *"Medical Negligence as a Human Rights Concern"* (2025) SSRN https://ssrn.com/abstract=5331494 .

[9] Soji Odunsi, *Medical Negligence and Its Litigation in Nigeria* (2023) 2 *Beijing Law Review* 45–54.

legal implications, systemic barriers; cost, weak enforcement, fragmented statutes, and socio-cultural influences; fatalism, trust in doctors. These literatures inform our study by illustrating where gaps lie between what the law *says* and what stakeholders *know and do*.

## Theoretical Framework

Negligence is fundamentally a tort concept rooted in duty of care. At its core is the *Donoghue v Stevenson* (1932)[10] "neighbour principle": a duty exists to avoid acts foreseeably causing harm to those closely affected. In Nigeria this underpins medical duty of care: the Supreme Court in *U.T.B. (Nig.) v. Ozoemena* defined negligence as "lack of proper care and attention; careless behaviour or conduct; [a] breach of duty of care… resulting in damage[11]". Thus the classic elements of negligence apply: (1) duty of care owed; (2) breach of that duty; and (3) harm caused by the breach. Normally, the plaintiff bears the burden to prove these elements; only in rare cases will *res ipsa loquitur* ("the thing speaks for itself") allow an inference of negligence.

A key theoretical nuance is the standard of care. In general negligence, the standard is what a reasonable person would do. In the medical context, courts apply a "skilled man" standard: the doctor must meet the standard of a reasonably competent practitioner in that field. This is known as the *Bolam* test: a doctor is not negligent if acting in accordance with a practice accepted by a responsible body of medical opinion[12]. However, *Bolitho* refinement allows courts to reject an opinion that is not "logically defensible[13]". In Nigeria, judges have endorsed that negligence must be such that the doctor's actions are judged a "mistake by professional colleagues". Importantly, Nigerian courts hold that *inexperience is no defence*: even trainee doctors are held to a high standard. Conversely, not every medical error is negligence – only those deemed unacceptable by a body of competent peers.

From a socio-legal perspective, medical negligence can also be viewed as a rights violation. Every Nigerian has a constitutional right to life and has been argued to include a right to health[14]. Under international law and Africa's Charter, the right to health is guaranteed to Nigerians[15]. Thus failure of healthcare providers to meet minimum standards can be seen as infringing fundamental rights. This theoretical lens underscores our focus: if medical negligence breaches basic rights, then gaps in law and practice directly translate into rights violations.

In connecting theory to our topic, note that *legal theory presumes* a functioning duty/standard scheme that deters negligence. But if public or professionals lack knowledge of these duties, or if

[10] AC 562, UKHL 100, or 1932 SC (HL) 31.
[11] U.T.B. (Nig.) Ltd v. Ozoemena (2007) 1 SC (Pt. 2) 211.
[12] Lewis C. Editorial: consent to treatment: Supreme Court discards Bolam principle. Med Leg J 2015;83:59–61. 10.1177/0025817215582167
[13] Bolitho v City & Hackney Health Authority [1997] UKHL 46

[14] Section 33, 1999 Constitution (As Amended)
[15] ICESCR Art.12

courts fail to apply the standard rigorously, then the theoretical protections cannot yield real accountability. Our analysis will hence examine how the above principles play out amid Nigeria's statutory and institutional framework, and why they fail to translate into effective enforcement.

## Nigerian Legal Framework and Case Law

Nigeria has no single "Medical Negligence Act"; instead, negligence claims rely on general tort law supplemented by various statutes and codes. Key legal sources include: the 1999 Constitution (As Amended) guarantees fundamental rights, including life and liberty, which courts interpret as encompassing the right to health and healthcare[16]. Medical and Dental Practitioners Act 2004 (Cap. M8, LFN) – regulates medical licensing and professional conduct. It imposes obligations on practitioners and establishes the Medical and Dental Council of Nigeria. The Council's Rules of Professional Conduct (a regulation under the Act) explicitly list forms of medical negligence like failure to attend, wrong diagnosis and incompetence[17]. Evidence Act 2011 – sets general standards of proof. In medical cases, the patient-complainant bears the burden and must prove duty and breach. The Act also defines "expert" witnesses and allows *res ipsa loquitur* [18]. Also, the criminal Code Act (Northern states) & Penal Code Act (Southern states), contain offences for negligence. For example, serious negligence causing death or grievous harm can attract criminal liability Criminal Code s.333 on manslaughter by negligence[19]. The Lagos State Criminal Law (2015) similarly penalizes reckless endangerment. National Health Act 2014 – provides a right to emergency treatment (s.22) and imposes liability where its provisions are violated[20]. While not exclusively about negligence, it is often cited in cases involving failure to provide care.

Other statutes include the HIV/AIDS (Anti-Discrimination) Act 2014 (prohibiting medical neglect of patients with HIV/AIDS) and the Gunshot Act 2017 (on mandatory treatment for gunshot victims). These highlight the legal duty to treat patients in certain contexts. Together, these laws establish that Nigerian healthcare providers have a legal duty to maintain a standard of care, and that failures can attract civil damages or even criminal sanctions. However, no provision specifically streamlines medical malpractice claims (e.g. there is no specialized tribunal).

## Relevant Case Law

Judicial decisions have fleshed out the principles of medical negligence in Nigeria: *U.T.B. (Nig.) Ltd v. Ozoemena* (2007) , The Supreme Court defined negligence as "lack of proper care and attention" breaching a duty of care. This case affirmed that the doctor–patient relationship imposes a duty akin to the neighbour principle. *Otti v. Excel-C Medical Centre Ltd & Anor* (2016). The

[16] Section 33, 1999 Constitution (As Amended)
[17] Medical and Dental Practitioners Act 2004 (Cap. M8, LFN)
[18] S.47, Evidence Act 2011
[19] Criminal Code s.333
[20] S 22, National Health Act 2014

Court of Appeal emphasized that to prove medical negligence, the defendant's actions must fall "short of the standard expected of a reasonably skillful medical professional[21]." In other words, negligence is a "mistake by professional colleagues". This case reiterates the Bolam standard in Nigerian jurisprudence and the requirement that a body of competent medical opinion deems the conduct negligent. *Delta State Hospitals Mgt. Board v. Onome* (2017), The Court of Appeal held that the plaintiff must prove the defendant owed a duty of care and breached it[22]. This underscores that medical negligence is treated as any other negligence tort, requiring proof of duty, breach, and damage.

The Lagos State *Dr. Orji* case (2019, not yet reported) involved criminal charges against an orthopaedic surgeon for applying an excessively tight cast, resulting in grievous bodily harm. Although this was criminal law, the trial court essentially found recklessness/negligence. It illustrates that extreme medical misconduct may attract criminal liability when it "endangers human life".In practice, few reported Nigerian cases hinge solely on medical negligence. A notable older case is *Ojo v. Gharoro (2004)* (CA) on medical malpractice damages, and *Anagu v. ACG* (1991) which held hospitals vicariously liable for staff negligence. But most tort law cases involve contracts or products; pure medical negligence litigation remains rare.

**Gaps Between Legal Provisions, Knowledge, and Implementation**

The foregoing analysis reveals a *disconnect* between what the law provides and what happens on the ground. Several interrelated gaps stand out; Legal and Awareness Gap: Although statutes and case law theoretically protect patients, many citizens and even doctors lack knowledge of these rights and duties. Studies show patients are unaware of legal remedies: Obaro notes that victims often do not know how to seek redress or even demand justice. Similarly, medical professionals commonly lack awareness of their own legal liabilities or the availability of professional indemnity insurance. An academic seminar highlighted that Nigerian patients generally *do not know* the standard of care they are entitled to, nor how to enforce it. Consequently, even where the law imposes a clear duty ( MDPA or Code of Ethics provisions), failure to communicate these rights means violations go unchallenged.

1. **Knowledge vs. Implementation Gap:** Even when victims or their families suspect negligence, few litigate. Cultural and practical barriers inhibit enforcement. Many Nigerians exhibit a "fatalistic" attitude, believing that injuries are acts of fate rather than someone's fault. Financial constraints and high legal costs discourage poor patients from suing. Administrative hurdles such as difficulty obtaining medical records or expert testimony further stymie claims. Empirical findings reflect this: in Iloh et al.'s survey, not a single doctor who committed an error faced a lawsuit. Adegboyega similarly documents

[21] *Otti v. Excel-C Medical Centre Ltd & Anor* (2016)
[22] *Delta State Hospitals Mgt. Board v. Onome* (2017)

that despite frequent negligence occurrences, very few cases are reported or litigated. In practice, patients may resign themselves ("move on"), especially if a disclosure by the doctor pacifies them. Thus, low awareness compounds low enforcement.

2. **Legal vs. Implementation Gap:** Several formal legal provisions exist (see above), but their enforcement is weak. The fragmented statutory framework – with provisions scattered in different laws and regulations – creates uncertainty. For example, basic rules on negligence reside in common law and the Evidence Act, while health-specific duties are implicit in Acts like the MDPA and NHA. This fragmentation means there is no one-stop regulation of malpractice, complicating enforcement. Moreover, Nigeria lacks specialized medical tribunals; malpractice cases are handled in regular courts ill-equipped to manage technical evidence. The default requirement that claimants prove negligence **"**beyond reasonable doubt**"** (as noted by Obaro) is particularly onerous, effectively hampering many claims.

In addition, systemic weaknesses in the healthcare system – chronic underfunding, obsolete equipment, brain-drain – set the stage for negligence. Patients' mistrust of the system is heightened when even public officials seek treatment abroad. These failures can discourage confidence in legal remedies. Finally, corruption and inefficiency in the judiciary (long delays, backlogs) undermine trust that suing will yield justice.

In summary, there is a *trifecta* of gaps: statutory provisions vs. stakeholder knowledge vs. real-world enforcement. Even robust laws are ineffective if stakeholders do not know them, and vice versa. For instance, the MDPA requires a high standard in emergencies, but a Nigerian doctor might not face any consequence for gross neglect simply because the patient didn't sue or because the evidentiary burden was not met. The result is that medical negligence often goes unremedied, despite the existence of a legal framework on paper.

## Conclusion and Recommendations

This study finds that Nigeria's legal regime for medical negligence is *well-intentioned* but under-implemented. The law (drawing on general negligence principles and various statutes) embodies clear duties for healthcare providers, yet millions of patients remain effectively unprotected. Major gaps in awareness, coupled with institutional barriers, mean that patients seldom obtain redress even for severe harm. This outcome is contrary to both tort principles and Nigeria's commitment to a right to health.

To bridge these gaps, multi-pronged reforms are needed:

1. **Raise Public Awareness:** Nationwide campaigns should educate patients about their health rights and when to seek legal advice. Consumer-advocacy NGOs and

government agencies can distribute information on medical negligence and redress procedures. Informing patients and relatives that they have legal recourse is a critical first step.

2. **Medico-Legal Training:** Incorporate medicolegal education into medical and nursing curricula and continuous professional development. Doctors should be trained on ethical and legal obligations (e.g. the Code of Ethics) and on best practices in patient care and record-keeping. Periodic seminars for healthcare workers can emphasize standards of care and liability issues. This will reduce ignorance among practitioners about the legal consequences of negligence.
3. **Mandatory Professional Indemnity:** Require hospitals and clinics (especially private ones) to maintain professional indemnity insurance for doctors. This ensures that if a suit is successful, compensation can actually be paid. It also motivates physicians to practice safely if they bear insurance costs. Insurance awareness programs and possibly subsidies for coverage could encourage uptake among physicians who currently see it as optional.
4. **Simplify Legal Procedures:** Amend the Evidence Act or procedural laws to ease the proof burden in medical cases. For example, statutory presumptions could be introduced (as in many jurisdictions) such as making hospitals produce records on demand, or shifting burdens when negligence is evident (expanded *res ipsa loquitur*). Developing special rules for medical cases (similar to Texas's evidentiary code) might improve access to justice. Additionally, alternative dispute resolution (ADR) mechanisms (medical arbitration panels or ombudsman offices) could resolve claims faster and less adversarially, as suggested by Opara.
5. **Strengthen Institutions:** Enhance the capacity and independence of regulatory bodies. The Medical and Dental Council should actively enforce the Code of Ethics and discipline errant practitioners, not just rely on court cases. An empowered patient complaints unit in hospitals, as provided by the National Health Act, could channel grievances into formal investigations. Public hospitals should publish negligence statistics and reforms. On the judicial side, creating specialized medical negligence courts or training judges on health matters could improve adjudication.
6. **Invest in Health Infrastructure:** As multiple experts note, improving the healthcare system overall will mitigate negligence. This means better funding, updated equipment, and adequate staffing to reduce errors. While beyond the scope of law, such improvements reduce the incidence of negligence at its source. Governments should not view compensation as a substitute for prevention.

In conclusion, closing the gaps requires both legal and societal change. Laws must be made accessible and enforced, while citizens must be empowered to use them. As one commentator puts it, the duty of care imposed by law should no longer "be left to the whims and caprices of medical

practitioners". Only by aligning Nigeria's medical negligence law with public knowledge and effective enforcement can the rights to life and health be meaningfully upheld.

**Bibliography**

Adesina A. Lawal, "An Insight into Medical Negligence under Nigerian Jurisprudence" *LawPavilion* Blog (Oct 2021).

AUN Faculty of Law, "Duty of Care: Law Professor on Why Patients, Relatives Should Tackle Medical Negligence" (14 Nov 2019) *AUN ThisWeek*.

Delta State Hospital Mgt Board v. Onome (2017) 6 NWLR (Pt. 1569) 163.

Ezinne V. Edu & Chidinma B. Nwakoby, "Medical Negligence in Nigeria: A Critical Analysis" (2023) *JEHMSS* Apr–May:7–24.

Gabriel U. P. Iloh *et al.*, "Medical Errors in Nigeria: A Cross-Sectional Study of Medical Practitioners in Abia State" (2017) *Archives of Med & Health Sci* 5(1):44–49.

Jude O. Adejumo & B. O. Adejumo, "Legal Perspectives on Liability for Medical Negligence and Malpractices in Nigeria" (2020) *Pan Afr Med J* 35:184.

Kamorudeen Adegboyega, "Medical Negligence in Nigeria and the Obstacles to Litigation" (2023) *International Journal of Social Sciences* 11(1):23–34.

Lewis C. Editorial: consent to treatment: Supreme Court discards Bolam principle. Med Leg J 2015;83:59–61. 10.1177/0025817215582167

Maxwell C. Opara, *Legal Framework for Proof of Medical Negligence in Nigeria* (2025) 19(3) AJARR 20–32.

Michael, *"Medical Negligence as a Human Rights Concern"* (2025) SSRN https://ssrn.com/abstract=5331494 .

Obaro, "Legal Imperatives of Medical Negligence and Medical Malpractice" (2022) *Nigerian J of Medicine* 31(5):598–603.

Ogorchukwu A. Isimoya & Samson I. Nwankwo, "Medical Malpractice and Awareness of Professional Liability Insurance among Physicians in Nigeria" (2020) *Annals of*

*Dunarea de Jos Univ (Economics & Informatics)* XXVI(2):57–68.

Ogunleye *et al.*, "Comparative Analysis of Medical Negligence between Nigeria and USA (Texas): Case Study, the State of Nigeria and Texas" (2023) 3 *International Journal of Innovative Science & Eng Tech* 10–24.

Otti v. Excel-C Medical Centre Ltd (2016) LPELR-25633(CA).

Queen Ukpo & Koski Obruche, "An Overview of the Concept of Medical Negligence in Nigeria" *Mondaq* (3 Mar 2024).

Soji Odunsi, *Medical Negligence and Its Litigation in Nigeria* (2023) 2 *Beijing Law Review* 45–54.

U.T.B. (Nig.) Ltd v. Ozoemena (2007) 1 SC (Pt. 2) 211.

Ushie, F. A. et al, "Patients' Knowledge and Perceived Reactions to Medical Errors in a Teaching Hospital in Nigeria" (2013) *African Health Sci* 13(3): 593–600.