

Medical Negligence and Patients' Rights in Nigeria: Towards Strengthening Accountability in the Healthcare System.

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ABSTRACT

Medical negligence is not just about mistakes made by doctors or other health workers. It is also about the right of patients to receive safe treatment, clear information, respectful care, proper explanation when something goes wrong, and fair compensation when avoidable harm occurs. In Nigeria, several laws and professional rules protect these rights. They include the National Health Act 2014, the Patients' Bill of Rights, consumer protection laws, professional codes of conduct and the general law of negligence. However, having these laws does not always mean that patients receive proper protection or that health workers and institutions are held responsible when mistakes occur. This article examines medical negligence, patients' rights and accountability in the Nigerian healthcare system. It uses legal analysis and a structured review of previous studies. Twenty-two Nigerian studies published between 2020 and 2024 were examined to identify common problems in healthcare practice. More recent legal studies published in 2025 were also considered to determine whether these problems are still present. The review identified five major problems. These are poor knowledge of patients' rights and informed consent, failure to report medical errors, fear of blame among health workers, pressure caused by staff shortages and heavy workloads, and difficulties faced by patients when trying to prove negligence or obtain compensation. Available Nigerian studies show that patients may have legal rights but may not clearly understand treatment risks, complaint procedures or the Patients' Bill of Rights. Health workers may also fail to report mistakes because they fear punishment, lack clear reporting procedures or work under difficult conditions. Patients who take legal action may face other problems such as high legal costs, long court processes, difficulty obtaining medical records and the need for expert evidence. The article therefore proposes a practical accountability model that brings together patients' rights, honest disclosure of medical errors, safe reporting systems, responsibility of healthcare institutions, accessible complaint procedures, fair professional discipline and measures that prevent similar mistakes from happening again. Accountability in healthcare should not end with punishment. It should involve preventing avoidable harm, explaining what happened when mistakes occur, investigating the cause, providing a fair remedy to affected patients and using the lessons from each case to improve patient safety.

1.0.Introduction

Healthcare is built on trust, but trust does not remove the possibility of error. A patient may be harmed by a wrong diagnosis, delayed treatment, poor monitoring, a medication mistake, an avoidable surgical injury, failure to refer, inadequate consent or refusal of urgent care. Some adverse outcomes occur even when clinicians act carefully; others arise because the expected standard of care was not met. The legal question is therefore not whether every bad outcome should attract liability. It is whether a healthcare professional or institution owed a duty, failed to meet the legally acceptable standard, and caused harm that can be linked to that failure. Nigerian scholarship has repeatedly stressed this distinction between an unfortunate clinical outcome and actionable negligence (Adejumo & Adejumo, 2020; Obaro, 2022).

The patient-rights question is wider than negligence. A person can receive technically competent treatment and still have a right violated if important information is withheld, consent is not properly obtained, confidentiality is breached, the patient is treated without dignity, or a complaint is blocked.

The National Health Act 2014 addresses emergency treatment, information, records, confidentiality and complaints. The Patients' Bill of Rights also brings together practical expectations relating to information, privacy, quality care, emergency treatment, consent and complaint. Olusegun and Odunsi (2023) argue that this framework is important but remains limited by implementation and the legal status of some rights. In practice, the central problem is not simply the absence of rules; it is the gap between formal protection and the patient's ability to use that protection.

Recent empirical evidence makes the implementation problem visible. In a tertiary hospital in Southwest Nigeria, only 46.8% of physicians and patients surveyed were aware that the Patients' Bill of Rights existed, and only 23.8% reported awareness of its contents (Adejumo et al., 2020). Studies of informed consent in Port Harcourt and Northwest Nigeria also found that patients were often asked to consent without receiving full information about complications or treatment choices (Okagua & Okagua, 2020; Grema et al., 2022). These findings matter because informed consent is not a signature exercise. It is a process through which the patient receives understandable information and makes a voluntary choice. Where this process is weak, legal rights exist on paper but patient autonomy is reduced at the point of care.

Accountability is also affected by what happens after an error. Afolalu et al. (2021) found suboptimal error reporting among doctors and nurses in a Nigerian hospital, with many respondents describing ineffective reporting systems, lack of confidentiality and a blame culture. Related safety-culture studies report weaknesses in non-punitive response to error, staffing and event reporting (Nnebue et al., 2021; Kaware et al., 2022). These weaknesses can create a closed cycle: staff fear reporting, management receives incomplete information, recurring hazards are not corrected, and patients have fewer opportunities to understand what went wrong. An accountability system that only punishes individuals after serious harm but fails to learn from routine incidents is therefore incomplete.

The justice system creates another layer of difficulty. A claimant must establish duty, breach, causation and damage, usually through records and expert evidence. Nigerian legal studies identify litigation cost, delay, evidentiary complexity, restricted access to expert witnesses and weak institutional enforcement as practical obstacles (Adegboyega, 2024; Odoeme et al., 2023). More recent work continues to call for clearer procedures, stronger inter-agency coordination, and easier access to evidence and alternative dispute resolution (Opara, 2025; Bamidele et al., 2025). The result is an accountability gap at both ends of the system: prevention and reporting may be weak before a dispute arises, while proof and remedy may be difficult after harm has occurred. This article addresses that gap by bringing legal rules, patients' rights and patient-safety evidence into one analysis.

1.1 Objectives of the study

The study has three objectives:

1. to explain the legal and practical meaning of medical negligence and patients' rights in Nigeria;
2. to review recent evidence on how accountability operates in healthcare settings; and,
3. to propose a model that links individual professional responsibility with institutional learning and accessible redress.

The paper argues that accountability should not be reduced to litigation or professional punishment. A stronger approach protects patient rights before harm, creates safe routes for disclosure and complaint, distinguishes system failure from reckless conduct, provides proportionate remedies, and feeds lessons back into healthcare practice.

2.0 Literature Review

2.1 Conceptual Review

2.1.1 Medical negligence and medical error

Medical negligence is a form of professional negligence. In simple terms, it arises when a healthcare professional who owes a patient a duty of care acts or fails to act below the standard reasonably expected in the circumstances, and that breach causes legally recognised harm. The concept therefore has four connected elements: duty, breach, causation and damage. Adejumo and Adejumo (2020) explain that medical liability in Nigeria may extend beyond tort to contract, criminal law, fiduciary obligations and fundamental rights, depending on the conduct involved. Obaro (2022) similarly notes that negligence and malpractice can have both civil and criminal consequences, although the threshold for criminal responsibility is not the same as ordinary civil negligence.

Medical error is broader than actionable negligence. An error can result from a reasonable but unsuccessful clinical judgment, a communication failure, a poorly designed process, a medication mix-up, an equipment problem or an individual lapse. Not all errors produce injury, and not all injuries prove negligence. This difference is important because a fair accountability system must avoid two extremes: treating every adverse outcome as professional misconduct, or treating preventable harm as an unavoidable feature of medical practice. The recent Nigerian literature increasingly links preventable harm to organizational conditions such as weak safety systems, limited training, staffing pressure and poor reporting mechanisms (Kenneth et al., 2023; Tamuno-opubo et al., 2024).

The legal standard is also context-sensitive. Courts examine what a reasonably competent practitioner would have done, the clinical circumstances, the information available at the time and whether the breach caused the injury. In *Ojo v. Gharoro* (2006) 10 NWLR (Pt. 987) 173, the Supreme Court considered a negligence claim arising from a broken surgical needle and discussed proof, expert evidence and *res ipsa loquitur*. The case remains useful because it shows that the occurrence of harm does not automatically decide liability. The claimant still needs legally acceptable evidence connecting the defendant's conduct to the injury, unless the circumstances permit an inference under established rules.

2.1.2 Patients' rights in healthcare

Patients' rights convert basic ethical expectations into claims about how people should be treated when they seek care. The core interests include autonomy, information, consent, privacy, confidentiality, access to records, dignity, non-discrimination, emergency care, quality and the ability to complain. These rights are closely connected: a patient cannot make a meaningful choice without information; cannot challenge poor care without access to records; and may be reluctant to complain if confidentiality or respectful treatment is uncertain. Kwame and Petrucka (2022) show in a broader rights-based review that communication and respect for patient rights support participation, satisfaction and people-centred care.

Nigeria's National Health Act gives several of these interests statutory form. Section 20 prohibits refusal of emergency medical treatment. Section 23 requires information on health status, available diagnostic and treatment options, benefits, risks, costs and consequences, as well as the right to refuse services, and expects communication in a language and manner the patient can understand. Sections 25–29 address records and confidentiality, while section 30 provides for complaints. The Patients' Bill of Rights places similar ideas in a clearer public-facing form. However, rights are effective only when patients know them and institutions build procedures around them. The awareness gap reported by Adejumo et al. (2020) and Onyi et al. (2024) suggests that public-facing rights education remains uneven.

Consent is one of the clearest points where legal rights meet daily clinical practice. Nigerian surgical studies show that many patients consent to procedures without receiving complete explanations of complications, alternatives or long-term consequences (Okagua & Okagua, 2020; Wichendu et al., 2021; Grema et al., 2022). The Supreme Court's decision in *Medical and Dental Practitioners*

Disciplinary Tribunal v. Okonkwo (2001) 7 NWLR (Pt. 711) 206 also confirms the importance of personal autonomy and competent refusal of treatment. Consent therefore protects more than the clinician from legal complaint; it protects the patient's authority over what is done to his or her body.

Rights may also be affected by social vulnerability. Folayan et al. (2022), studying HIV and sexual and reproductive health services in Nigeria, found reported violations involving privacy, respect, complaint and consent, with some vulnerable groups facing higher odds of violation. International evidence likewise shows that patient-rights knowledge among health professionals can be inconsistent, especially around information and participation (Mpouzika et al., 2021). These findings support a practical definition for this article: patients' rights are enforceable or normatively recognised entitlements that require healthcare providers and institutions to treat patients as informed participants rather than passive recipients of care.

2.1.3 Healthcare accountability

Healthcare accountability is the process through which duties are defined, performance can be questioned, failures are examined, responsibility is fairly assigned, remedies are provided, and lessons are used to improve future care. It therefore has preventive, explanatory, corrective and disciplinary parts. Litigation is one route, but it is not the whole system. Complaints procedures, professional regulation, hospital incident reporting, clinical audit, disclosure, consumer protection and organizational quality improvement also matter. Studies of patient feedback show that complaints can provide useful safety information when organizations analyze patterns rather than treating each complaint as an isolated customer-service problem (van Dael et al., 2020; Wong et al., 2020).

A mature accountability system must also separate blame from responsibility. Some events arise from ordinary human error within unsafe systems; some involve risky shortcuts encouraged by poor work design; and some involve reckless disregard of clear duties. Treating all three categories identically can reduce reporting and hide hazards. Barkell and Snyder's (2021) review of Just Culture describes the need for balance between learning and accountability. This balance is especially relevant to Nigeria because several local studies identify non-punitive response to error as a weak area (Nnebue et al., 2021; Kaware et al., 2022). The goal is not to remove personal responsibility but to make the response proportionate to the nature of the conduct and the system conditions surrounding it.

Table 2.1. Core concepts used in the article

Concept	Working meaning	Main legal/practice question	Key indicators
Medical negligence	Breach of a professional duty of care that causes legally attributable harm.	Was the required standard of care breached, and did the breach cause damage?	Duty, breach, causation, damage, expert evidence.
Patients' rights	Entitlements concerning autonomy, information, consent, dignity, privacy, records, emergency care, quality and complaint.	Could the patient understand, choose, participate and seek redress?	Rights awareness, consent quality, confidentiality, records, complaint access.
Healthcare accountability	Processes that prevent harm, explain failures, assign fair responsibility, provide	Can the system detect problems, respond fairly and prevent recurrence?	Incident reporting, disclosure, complaint handling, discipline,

remedy and support
learning.

compensation, system
improvement.

2.2 Theoretical Framework

This study uses an integrated Rights–Just Culture accountability framework. The first part is rights-based. It treats the patient as a person with legally and ethically protected interests before, during and after treatment. Information and consent support autonomy; confidentiality protects private life; access to records supports continuity and proof; emergency-care duties protect life and timely access; and complaint mechanisms give practical meaning to the right to challenge poor treatment. A rights-based approach also requires transparency and non-discrimination. Olusegun and Odunsi (2023) show that Nigeria’s Patients’ Bill of Rights is an important organizing instrument, while Kwame and Petrucka (2022) explain why rights and communication are central to people-centred healthcare.

The second part is Just Culture. This approach asks why an unsafe event occurred before deciding who should be blamed. Human mistakes call for system redesign and support; at-risk choices may require coaching and removal of incentives for unsafe shortcuts; reckless conduct may justify discipline. The value of this approach is its ability to protect learning without creating impunity. Barkell and Snyder (2021) identify error management, balance, leadership and systems change as central themes. In Nigeria, this is not an abstract concern: Afolalu et al. (2021) found that blame and concerns about confidentiality were barriers to error reporting, while Nwosu et al. (2022) found weaknesses in reporting and non-punitive response in the operating-room setting.

Combining both approaches produces a more complete theory of accountability. Patient rights prevent the idea of “system error” from becoming an excuse for failing to disclose harm or provide remedy. Just Culture prevents the rights framework from becoming a purely punitive model that frightens staff into silence. The integrated approach therefore requires both answerability to patients and organizational learning. It also recognises institutional responsibility: a hospital that provides inadequate staffing, poor equipment, weak supervision or an unusable reporting system can contribute to the same adverse event for which an individual clinician may later be blamed. This is consistent with recent Nigerian work calling for clearer hospital liability and stronger institutional mechanisms (Nnubia, 2025; Kolo & Mafuyai, 2025).

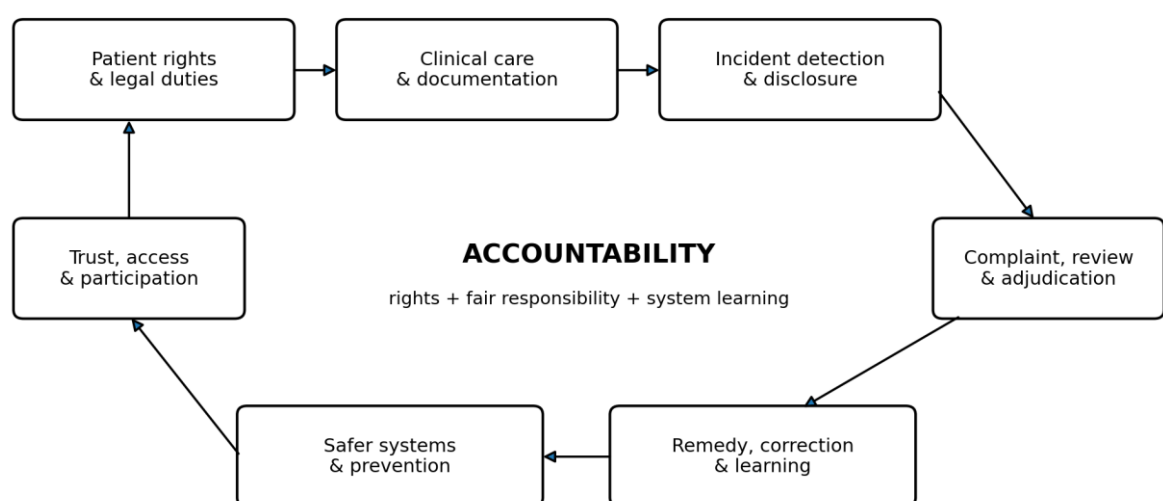


Figure 2.1. Integrated Rights–Just Culture Accountability Model.

2.3 Empirical Review

Recent Nigerian research is fragmented across law, patient-rights studies, consent studies and patient-safety surveys. The empirical literature does not yet provide a national incidence rate for medical negligence, but it gives a consistent picture of the conditions that shape accountability. The studies in Table 2.2 were selected because they provide direct evidence on patients' knowledge, informed consent, rights violations, error reporting, safety culture or communication. The table is deliberately concise so that it remains readable on a portrait page.

Table 2.2. Selected empirical studies on patients' rights, safety and accountability in Nigeria

Author/year	Setting/design	Sample	Main finding	Relevance
Adejumo et al. (2020)	Southwest tertiary hospital; cross-sectional	453	46.8% knew PBoR existed; 23.8% knew its contents.	Rights awareness gap.
Okagua & Okagua (2020)	Port Harcourt; post-caesarean survey	348	Most knew the diagnosis, but many lacked information on possible complications.	Consent quality.
Iloh et al. (2020)	Southeast Nigeria; doctor survey	Doctors	Resource and system barriers affected patient-safety practice.	Prevention context.
Afolalu et al. (2021)	Nigerian hospital; cross-sectional	230	Reporting was suboptimal; blame, unclear systems and confidentiality concerns were barriers.	Error disclosure/reporting.
Nnebue et al. (2021)	Tertiary hospital; safety-culture survey	Care providers	Overall safety culture 62.3%; non-punitive response was weakest; 54% never reported events.	Learning culture.
Wichendu et al. (2021)	Port Harcourt; surgical-patient survey	Patients	Counselling and understanding of surgical information were uneven.	Informed consent.
Kaware et al. (2022)	21 Katsina public hospitals; survey	460 nurses	Staffing, non-punitive response and reporting frequency were key weak areas.	Organizational safety.
Grema et al. (2022)	Northwest tertiary hospital; cross-sectional	244	Important short- and long-term complications were not consistently explained.	Consent disclosure.



Folayan et al. (2022)	Nigeria HIV/SRH services; cross-sectional	2,119	Respondents reported violations involving privacy, respect, complaint and consent.	Rights enforcement.
Nwosu et al. (2022)	Operating rooms; HSOPSC survey	122	Overall composite was 47%; reporting, staffing and non-punitive response were weak.	Safety systems.
Abel et al. (2023)	Ibadan; cross-sectional HSOPSC	271	Overall culture 72.1%; reporting events was lowest at 47.4%.	Reporting weakness persists.
Buowari & Ikpae (2024)	Port Harcourt emergency unit; cross-sectional	197	Most knew diagnosis/treatment, but 59.4% lacked knowledge of medicine side effects.	Information quality.
Onyi et al. (2024)	Anambra tertiary hospitals; survey	422	Many knew general rights but most were unaware of the PBoR itself.	Rights literacy.
Sani et al. (2024)	Birnin-Kebbi tertiary hospital; nurse survey	Nurses	Higher work stress was associated with weaker safety practice.	Workforce accountability.

2.4 Gap in Literature

The recent literature identifies many parts of the problem but rarely joins them into one accountability pathway. Rights studies show low awareness or incomplete consent (Adejumo et al., 2020; Grema et al., 2022), while safety studies show weak reporting, non-punitive response and staffing pressures (Afolalu et al., 2021; Kaware et al., 2022). Legal studies, in turn, focus on duty, proof, litigation and professional discipline (Odoeme et al., 2023; Adegboyega, 2024). The missing link is an integrated explanation of how these problems interact from the moment care is delivered to the point where a patient seeks a remedy. There is also little evidence connecting complaint data, incident reporting and legal redress into a shared learning system. This article responds by combining patients' rights, negligence law, safety culture and institutional responsibility within one model, and by distinguishing punitive accountability from learning-oriented accountability without weakening the patient's right to disclosure and remedy.

3.0 Methodology

The study adopted a doctrinal and structured integrative review design. The doctrinal component examined the Nigerian legal framework governing patient rights, professional duties, negligence and redress. Primary materials included the Constitution of the Federal Republic of Nigeria 1999 (as amended), the National Health Act 2014, the Federal Competition and Consumer Protection Act 2018, the Patients' Bill of Rights, the Compulsory Treatment and Care for Victims of Gunshots Act 2017, the

Code of Medical Ethics in Nigeria, and leading Supreme Court decisions. These materials were used to map what the law requires and the routes through which responsibility may arise.

The integrative component focused on authored scholarship published from 2020 to August 2026, with most included Nigerian empirical studies falling between 2020 and 2024 and the most recent legal analyses extending into 2025. Searches were undertaken across PubMed-indexed records, journal platforms and legal research repositories using combinations of medical negligence, malpractice, patients' rights, informed consent, patient safety, medical error reporting, healthcare complaints, hospital liability and Nigeria. Sources were retained when their authorship, publication details and relevance could be verified. Institutional materials were used only for primary law, policy or professional rules and were not counted toward the requirement for authored scholarly references.

A focused set of 22 Nigeria-centred publications from 2020–2024 was coded for recurring accountability themes. A publication could be assigned to more than one theme because, for example, a patient-safety study may discuss both reporting and staffing. The five coding categories were: safety/error reporting; rights awareness/informed consent; institutional or staffing constraints; regulatory/enforcement gaps; and litigation/proof/redress. The coding counts are descriptive signals of how often a problem appeared in the selected literature; they are not estimates of the national prevalence of negligence and should not be interpreted as effect sizes.

The 2025 legal publications were analyzed separately because they were mainly doctrinal rather than hospital-based empirical studies. They were used to assess whether litigation, institutional liability and enforcement problems identified in earlier literature remained current. No patient records, interviews or original clinical data were collected for this article, and no numerical findings were invented. Statistical values reported in the text and tables are taken from the cited studies. The analysis proceeded by comparing legal duties with evidence of actual practice, identifying points where the accountability chain breaks, and developing reforms that address both patient remedy and prevention.

4.0 Results

The review produced two related sets of findings. The doctrinal analysis shows that Nigeria already has several routes for protecting patients and holding providers accountable. The thematic synthesis shows that the weak point lies mainly in implementation: knowledge, reporting, institutional systems, enforcement and access to redress. This section presents the legal architecture first and then the recurring evidence themes.

4.1 Legal and Regulatory Accountability Architecture

Table 4.1. Main legal and regulatory routes relevant to medical negligence and patients' rights

Instrument/route	Main protection or duty	Accountability mechanism	Practical issue
National Health Act 2014	Emergency care; information; records; confidentiality; complaints.	Statutory duties, offences for specified breaches, complaint procedures.	Implementation varies across facilities.
Patients' Bill of Rights / FCCPA framework	Information, consent, privacy, dignity, quality, emergency care, complaint.	Consumer-protection investigation and redress plus provider obligations.	Public awareness and legal clarity remain uneven.



Medical and Dental Practitioners Act / MDCN ethics	Professional competence, conduct, confidentiality, emergency duty.	Investigation and Disciplinary Tribunal; sanctions.	Panel	Professional discipline does not automatically compensate patients.
Tort of negligence	Duty, breach, causation and damage.	Civil damages; possible institutional/vicarious liability.		Records, expert evidence, cost and delay can obstruct claims.
Constitutional/fundamental-rights claims	Life, dignity, privacy and related protections.	Court enforcement where facts fit enforceable rights.		Health obligations in Chapter II have justiciability limits.
Gunshot Victims Act 2017	Immediate treatment of gunshot victims without prior police clearance.	Criminal and regulatory consequences for unlawful refusal.		Implementation and provider understanding require strengthening.

The legal map shows that a harmed patient may have more than one route, but the routes serve different purposes. Professional discipline protects standards and may sanction a practitioner; civil negligence aims mainly at compensation; consumer-protection processes can address unfair or unsafe service practices; hospital complaint systems can provide explanation and local correction; and criminal law is reserved for conduct meeting a higher threshold. The problem is that patients may not know which route fits their complaint, and the institutions handling the routes do not always operate as a coordinated system. Recent Nigerian legal analysis therefore calls for better procedural integration rather than simply adding more offences (Opara, 2025).

Emergency care illustrates the importance of clear statutory duties. Section 20 of the National Health Act states that emergency treatment must not be refused. The Compulsory Treatment and Care for Victims of Gunshots Act 2017 adds specific protection for gunshot victims. Akinola and Uwandu (2025) argue that continued uncertainty around treatment obligations can have serious consequences. For accountability to be meaningful, emergency departments need simple protocols that staff understand, clear documentation of triage decisions, escalation routes and consequences for unlawful refusal.

4.2 Recurring Themes in the Nigeria-Focused Evidence

Table 4.2. Recurrence of accountability themes in the 22-publication focused synthesis

Theme	Publications coded	Share of focused set	Interpretation
Safety / error reporting	9	40.9%	Reporting and non-punitive response are repeated weaknesses.
Rights awareness / informed consent	8	36.4%	Formal rights do not always translate into understanding or participation.
Institutional / staffing constraints	7	31.8%	Workload, staffing, resources and system design affect safe practice.

Regulatory enforcement gaps	/ 7	31.8%	Rules exist, but coordination and implementation remain uneven.
Litigation / proof / redress	/ 5	22.7%	Evidence, expert access, cost and procedure can restrict remedies.

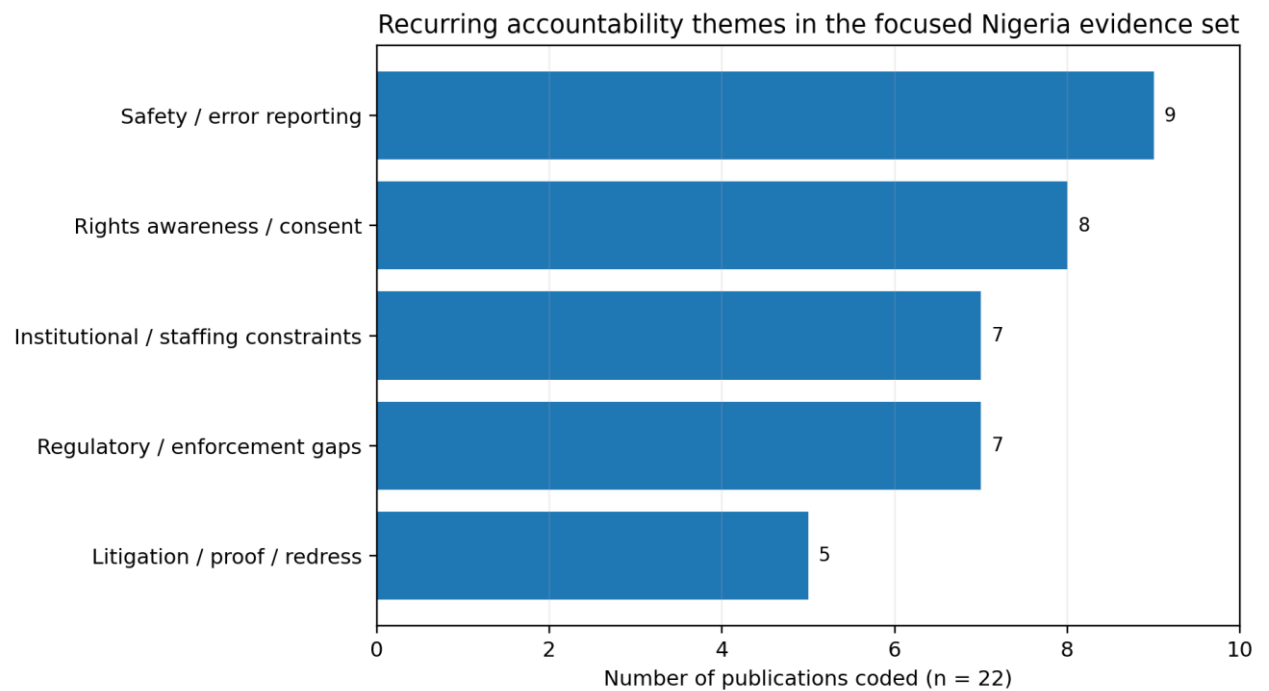


Figure 4.1. Recurrence of the five main accountability themes in the focused Nigeria evidence set.

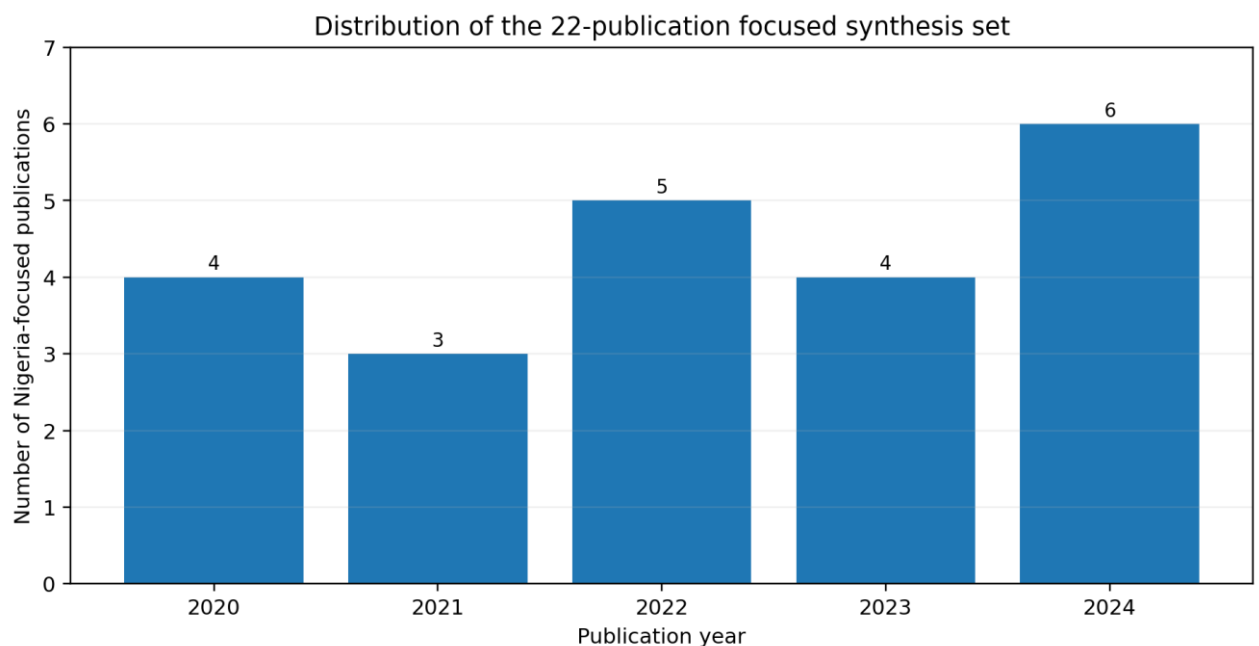


Figure 4.2. Publication-year distribution of the 22 publications used in the focused thematic synthesis.

4.3 Rights Awareness, Information and Consent

The evidence shows a difference between recognising a general right and knowing how to exercise it. Adejumo et al. (2020) found that less than half of participants knew that the Patients' Bill of Rights existed and less than one quarter said they knew its contents. Onyi et al. (2024) later found a similar pattern in Anambra State: patients could express awareness of rights in general while remaining unaware of the formal PBoR. This weakens accountability because a person who does not know that records, explanation, consent and complaint are protected interests may accept poor communication as normal.

Consent studies show the same problem at the bedside. Okagua and Okagua (2020) reported that many women undergoing caesarean section lacked information about possible complications. Grema et al. (2022) found that substantial proportions of surgical patients were not informed about immediate and long-term complications. Buowari and Ikpa (2024) found comparatively high awareness of diagnosis and treatment in an emergency setting, yet 59.4% of respondents did not know the side effects of their medicines. The pattern suggests that information is often partial: patients may know what is being done without receiving enough explanation to judge risks, alternatives or consequences.

4.4 Reporting, Safety Culture and Institutional Conditions

The most frequent theme in the focused synthesis concerned safety and error reporting. Afolalu et al. (2021) found that many nurses and doctors were unaware of reporting systems or regarded them as ineffective, with blame and confidentiality concerns discouraging reporting. Nnebue et al. (2021) recorded a fair overall safety-culture score but found non-punitive response to error to be the weakest dimension and reported that 54% of respondents never reported safety events. These findings show why relying on complaints or lawsuits alone will miss a large part of preventable harm: the healthcare organization may fail to capture early warning signals long before a patient reaches a court or regulator.

The weakness is not uniform across facilities, but it appears across regions. Kaware et al. (2022), studying nurses in 21 Katsina public hospitals, identified staffing, non-punitive response and frequency of events reported as areas requiring improvement. Nwosu et al. (2022) found an overall positive composite of 47% in operating-room safety culture, with weaknesses in reporting, staffing, communication and handoffs. Abel et al. (2023) later reported a stronger overall perception of safety culture in Ibadan, yet reporting patient-safety events remained the lowest-scoring dimension at 47.4%. Differences in overall scores may reflect setting and measurement, but the repeated weakness in reporting is notable.

Work conditions help explain why individual blame alone is inadequate. Sani et al. (2024) found that higher work-related stress was associated with poorer patient-safety practice among nurses in a tertiary hospital. Reviews of Nigerian patient safety also identify limited resources, inadequate training, weak regulation and technology gaps as system problems (Kenneth et al., 2023; Tamuno-opubo et al., 2024). A clinician remains responsible for professional choices, but an accountability model that ignores unsafe staffing, poor equipment or weak supervision can misidentify the source of risk and fail to prevent recurrence.

4.5 Proof, Complaint and Redress

Legal redress requires more than a patient's belief that care was poor. The claimant must obtain records, identify the relevant standard, show a breach and connect that breach to the injury. Adegboyega (2024) identifies cost, low awareness, judicial complexity and difficulty obtaining expert witnesses as obstacles to negligence litigation. Odoeme et al. (2023) likewise argue that Nigerian victims of medical error have historically struggled to obtain the relief that negligence law appears to offer in principle. Oluokun (2024) reaches a similar conclusion, linking weak enforcement and procedural barriers to the persistence of medical-negligence disputes. These barriers can produce a justice problem even where the substantive legal test is clear.

Recent doctrinal studies indicate that the same issues remain current. Opara (2025) emphasizes fragmented enforcement, limited awareness and the need for better coordination among tribunals, regulators and councils. Bamidele et al. (2025) call for updated legal provisions and stronger professional and judicial education, while Nnubia (2025) argues that hospital liability and institutional accountability require clearer practical enforcement. Kolo and Mafuyai (2025) add a consumer perspective, which is useful because patients obtain health services within relationships that involve information asymmetry and dependence. Together, these studies support accessible early complaint review, better records access, independent expert mechanisms and alternatives to long civil proceedings.

5.0 Discussion

The principal finding of this review is that Nigeria's accountability problem is not simply a shortage of legal rules. The country has statutory rights, professional ethics, negligence law, consumer-protection mechanisms and disciplinary bodies. The larger weakness is the connection between these parts. A right to information is weakened when patients do not know it exists; a duty to report incidents is weakened when staff fear blame; a right to complain is weakened when the complaint system is unclear; and a negligence action is weakened when records or expert evidence are difficult to obtain. Accountability therefore fails through a chain of small institutional breaks rather than one single legal defect.

The findings on rights awareness are consistent with international evidence that professional and patient knowledge of rights can be uneven. Mpouzika et al. (2021) found important knowledge gaps among nurses across the international studies they reviewed. Nigerian evidence adds a local implementation concern because a national PBoR exists but is not yet universally understood (Adejumo et al., 2020; Onyi et al., 2024). Rights information should therefore be treated as part of service delivery, not as a poster placed on a hospital wall. Admission forms, consent processes, discharge instructions and complaint channels can all be designed to explain rights in ordinary language.

The consent evidence has a similar implication. The fact that many patients say they are satisfied does not prove that consent was fully informed. Grema et al. (2022) reported high satisfaction while also identifying important gaps in disclosure of complications. Okagua and Okagua (2020) found a comparable disconnect. This matters because the legal purpose of consent is not merely emotional satisfaction but a valid decision based on relevant information. The principle in *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo* remains important: a competent patient's autonomous decision deserves respect. Hospitals should therefore audit the content and timing of consent, not simply check whether a form is signed.

The safety-culture evidence shows why accountability must include protected reporting and learning. Afolalu et al. (2021), Nnebue et al. (2021), Kaware et al. (2022), Nwosu et al. (2022) and Abel et al. (2023) were conducted in different settings, yet each raises a reporting or non-punitive-response concern. This pattern fits the Just Culture model. If routine mistakes are met with automatic punishment, staff may hide them; if reckless conduct is excused as a system problem, patient protection suffers. The better response is to examine behavior, system design and foreseeable risk together. Barkell and Snyder (2021) support this balanced approach because learning and fair responsibility are complementary rather than opposing goals.

Complaint handling should also be connected to patient safety. Research outside Nigeria shows that complaints contain information about failures that routine clinical reporting may miss (O'Dowd et al., 2020; van Dael et al., 2020). Wong et al. (2020) further show that patient feedback can support quality improvement when it is systematically translated into action. Nigerian hospitals could use the same principle by coding complaints by service, harm type, communication problem and recurrence. A

complaint about disrespect or missing information may not amount to negligence, but repeated complaints can reveal a pattern that later becomes a safety or legal risk.

Disclosure after an adverse event is another missing bridge. Patients generally need a clear account of what happened, what is known, what remains uncertain, what treatment is being provided and what the organization will do next. Olazo et al. (2022) show that preferences and perceptions of error disclosure may vary across populations, which means disclosure should be respectful and adapted to the patient's needs. Nigerian legal analysis on non-disclosure similarly treats concealment of error as inconsistent with patient rights. Open disclosure should not be confused with an immediate admission of legal liability; it is first an ethical and safety process for giving accurate information and preserving trust.

Institutional responsibility is especially important in resource-constrained environments. Iloh et al. (2020) drew attention to patient-safety challenges in a setting where resources are limited. Sani et al. (2024) linked work stress with safety practice. These findings do not excuse negligent conduct, but they show that preventable harm may be produced by organizational decisions about staffing, equipment, handoffs, supervision and workload. A legal framework centred only on individual doctors can therefore miss the contribution of hospitals and management systems. Nnubia (2025) is right to place hospital liability more clearly within the Nigerian tort discussion.

Litigation remains necessary because some cases require compensation, authoritative determination or serious sanction. But litigation should be the final layer of a broader system rather than the first practical opportunity for a patient to be heard. Adegboyega (2024) and Opara (2025) show how cost, evidence and procedure can make formal claims difficult. Earlier resolution mechanisms can provide explanations, record correction, apology, refund, treatment support or negotiated compensation where appropriate, while preserving access to court for disputed or severe cases. This is not a proposal to privatize justice. It is a way of preventing every complaint from depending on a long and expensive negligence suit.

A final point concerns emergency care. The statutory rule against refusal of emergency treatment is clear, yet high-risk situations such as gunshot injuries continue to generate legal and practical uncertainty. Akinola and Uwandu (2025) show the continuing need for provider guidance under the Gunshot Victims Act. Emergency accountability should focus on rapid triage, stabilization, documentation and referral. Hospitals should not make payment, police paperwork or administrative uncertainty a barrier to immediate care where the law requires treatment. Clear protocols would protect both patients and clinicians by reducing hesitation at the point where time is most critical.

6.0 Policy and Practice Recommendations

6.1 Make patients' rights operational at facility level

Every public and private health facility should convert the National Health Act and Patients' Bill of Rights into short operational standards. Patients should receive plain-language information on consent, records, privacy, emergency care, billing and complaint channels. Rights information should be available in major local languages and in formats suitable for low literacy. Compliance should be checked during facility accreditation rather than left as voluntary publicity.

6.2 Establish protected incident-reporting and open-disclosure systems

Hospitals should maintain confidential, easy-to-use systems for reporting near misses, errors and adverse events. Policies should clearly distinguish ordinary human error, unsafe shortcuts and reckless conduct. Staff who report in good faith should be protected from retaliation, while deliberate concealment or reckless practice should attract proportionate action. Serious events should trigger timely disclosure to the patient or family, clinical support and documented investigation.

6.3 Create independent patient-safety and complaint units

Large hospitals should have a patient-safety and complaints unit that is operationally separate from the clinical team directly involved in the disputed care. The unit should acknowledge complaints quickly, secure records, explain the process, classify risk, arrange clinical review and communicate outcomes. Aggregated complaint data should be reported to management and used to identify repeated service problems.

6.4 Improve access to records and independent expert review

Patients pursuing a complaint should be able to obtain relevant records within defined time limits, subject to lawful confidentiality safeguards. Courts, regulators and complaint bodies also need access to independent experts who are not professionally or institutionally conflicted. A national or state-level roster of trained medico-legal experts could reduce the difficulty of finding credible expert evidence.

6.5 Strengthen institutional liability and governance

Accountability should reach the organization where harm is linked to staffing, equipment, infection control, supervision, handover systems or management decisions. Hospital boards should receive regular patient-safety reports, including serious incidents, complaint patterns, corrective actions and unresolved risks. This would make safety a governance responsibility rather than a matter left only to individual practitioners.

6.6 Expand accessible dispute resolution without removing court rights

Health-sector mediation or specialized medical-negligence panels could provide faster review for suitable disputes. Participation should be fair and voluntary, and patients should retain access to ordinary courts. Outcomes involving serious professional misconduct should still be referred to the relevant regulator. The purpose is to create a practical route to explanation and remedy, not to shield providers from scrutiny.

6.7 Invest in workforce conditions and safety competence

Legal reform cannot compensate for unsafe systems. Government and facility managers should address staffing, work stress, supervision, continuing professional education, medication safety, handover quality and emergency readiness. Training should include communication, informed consent, documentation, disclosure and medico-legal responsibilities. Safer working conditions protect both patients and professionals.

6.8 Publish anonymized accountability indicators

Regulators and hospitals should publish periodic, anonymized data on complaints, serious incidents, disciplinary outcomes and corrective actions. Public reporting should avoid exposing individual patients, but it should show whether organizations learn from harm. Transparent trend data would also support future research, since the present literature cannot estimate a reliable national incidence of medical negligence.

7.0 Conclusion

Medical negligence and patients' rights in Nigeria should be treated as parts of the same accountability problem. The legal system already recognises important duties concerning competent care, emergency treatment, information, consent, confidentiality, records and complaint. Recent evidence, however, shows that these protections are weakened by limited rights awareness, incomplete consent, under-reporting of errors, blame-oriented safety cultures, staffing pressure and difficult routes to legal proof. A patient may therefore be protected in principle but still struggle to obtain explanation, correction or remedy in practice.

The most useful reform is not a choice between stronger punishment and a softer safety culture. Nigeria needs both fair responsibility and learning. Reckless or dishonest conduct should have consequences, but ordinary error and system failure should be investigated in ways that reveal why the event occurred and how recurrence can be prevented. Hospitals must also be accountable for the

conditions under which clinicians work. When rights education, open disclosure, incident reporting, independent complaint review, records access, proportionate discipline and compensation are linked, accountability becomes a cycle rather than a courtroom event. That cycle is more likely to protect patients, support responsible health professionals and improve trust in the healthcare system.

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