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Medical Negligence in the Courtroom: A Critical Examination of *the Patient-Centric Approach under the Consumer Protection Law in Nigeria*

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Abstract
The rights of patients are protected by the Constitution and several statutes. These rights include, among others, the right to quality health care, which involves access to competent, professional, and safe healthcare services. Regrettably, these rights have been breached and victims suffered legal incapacitation which results in the denial of those rights in a court of law. This situation was brought to the fore in the case of ***Ojo vs Gharoro*** which despite the damages suffered by the Appellant as a result of a broken surgical needle being forgotten in her abdomen during a surgical operation. Notwithstanding the obvious medical negligence on the part of the medical team, the patient lost the case on the grounds of her inability to prove by expert witness that the medical practitioners were negligent. The law and practice of medical negligence has moved away from what was obtainable in the case of ***Ojo vs Gharoro***. The new approach is to enable patients to access justice through the patient-consumer concept, which has widened the doctrine of standard of care and informed consent. This research will use doctrinal method to analyse both primary and secondary sources of existing legal materials. In x-raying this concept the following questions will be examined, namely: to what extent has the change in the standard of proof in medical negligence impacted on the right of patients to access justice? Put different, to what extent has the incorporation of patients' rights into the Consumer Protection enactment aid patient's right to access to justice in Nigeria? Secondly, can the principle of implied consent exempt medical practitioners from liabilities for medical negligence? This article established that Patient safety is recognised globally as a public health challenge. However, in practice, the courts are increasingly reluctant to interfere in clinical matters in order to protect and safeguard the integrity of the medical profession. This article argues that this approached adopted by the courts could have a far reaching effect leading to therapeutic immunity that may be detriment to the law. Consequently, this article recommends the need to strengthen patient care regulation to become "patient-centric" in order to enforce rights-based pursuit involving consumer protection.
Keywords: Medical Negligence, Implied Consent, Consumer protection, Access to Justice, Rights of Patients, *Res Ipsa Loquitur*
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1. Introduction

The role of the medical profession in the preservation of life cannot be overemphasized. It is acknowledged as a profession ordained by God for the treating and caring for the sick and wounded. The duty of the medical practitioner is one service, compassion and the application of skill, balanced with a reliance on God as the

ultimate source of healing.[1] However, there are instances where in the course of their duties, they cause more harm than good. This research provides an in-depth analysis of the principle of *res ipsa loquitur* in Nigerian medical law, using the *Ojo vs Gharoro*[2] case as a catalyst to explore the complexities and challenges of proving medical negligence in Nigeria. The summary of the facts in *Ojo vs Gharoro* are as follows: the Appellant, a patient of the first Respondent consented to a surgical operation for the removal of a growth in her fallopian tube to enable her get pregnant. The surgical operation was carried out by the 1st Respondent, assisted by the 3rd Respondent in the hospital owned by the 2nd Respondent. In the course of the operation, 1st and 3rd Respondents left a broken needle in the Appellant's womb, which resulted in great pains, discomfort and another surgical operation to remove the broken needle. Her action for damages was dismissed by the trial court and at the Court of Appeal and Supreme Court.

There are plethora of cases of injury and death occasioned by the negligent actions of medical practitioners in the world and Nigeria[3] not being an exception[4] resulting from lack of professional clinical care,[5] unsafe health facilities practices[6] and medical errors account for nearly twenty eight percent (28%) of errors of medical personnel.[7] For example, the Medical and Dental Council of Nigeria (MDCN) established a case of medical negligence and provisionally suspended the director of a private hospital and two other doctors following the death of Nkanu Adichie-Esege, the 21 month old son of renowned author Chimanmanda Ngozi Adichie who died on the 7th day of January, 2026 after complication that arose during preparatory medical procedures at Educare Hospital in Lagos state Nigeria.[8] Patient safety is recognized globally as a public health challenge and a fundamental principle of healthcare delivery[9] which is anchored on clinical governance[10], a framework designed to improve service quality, clarify professional responsibilities and integrate systems that reduced clinical errors.

Interestingly, there is a significant shift in how medical accountability is handled across different jurisdiction. Medical negligence has moved from purely clinical malpractice sphere into the broader consumer rights protection arena.[11] This new normal is not without legal consequences; for example, it has reclassified the doctor-patient relationship to that of service provider and consumer relationship where deficiency in service becomes actionable. This and many more legal concerns will be discussed in the course of this research.

2. Background

The case of *Ojo vs Gharoro*[12] was predicated on the principle of *res ipsa loquitur*. It was in evidence that the operation of Ojo was successfully performed by the 3rd Respondent. The fibroids were dealt with and removed and the patient was closed up. However, when the skin layer was being closed, the surgical needle got broken at

[1] Health and Faith – Should Christians go to Doctors? (2017) Available at <https//:www.learn.tearfund.org> Accessed on March 10, 2026 at 9:06am.
[2] *Ojo vs Gharoro* (2006) All FWLR (Pt. 316) Pages 241-242, Paras H-E.
[3] E Nwachukwu, "Health Sector Decay: Nigerians Dying Needlessly" Punch Newspaper, 13th September, 2021 Available at https://punchng.com/health-sector-decay-nigerians-dying-needlessly/ cited by S P A Ajibade, "A Review of Medical Negligence in the Nigerian Healthcare Sector: Utilising the Law as a Panacea" Available at https://www.spaajibade.com? Accessed 9th March, 2026 at 2:37pm.
[4] I P Enemo, "Medical Negligence: Liability of Health Care Providers and Hospitals" *Nigerian Juridical Review, Faculty of Law University of Nigeria, Enugu Campus* (2011-2012) 10, P.112-131
[5] Ofuebe, J Ifeoma and others, "Factors Contributing to Medical Errors in Healthcare Facilities in Nigeria: A Survey of Healthcare Stakeholder's Perspectives" (2022) *Journal of Engineering and Applied Sciences*, 13(12) Pp. 4314-4319.
[6] A Momoh, "Unsafe Hospital Care kills one in 24 Patients in Nigeria – Expert" The Guardian Nigerian, July 31, 2025. Available at <https://guardian.ng/features/health/unsafe-hospital-care-kills-one-in-24-patients-in-nigeria-expert/>Accessed March 11, 2026 at 12:41pm.
[7] NolPolls Limited, "Nigerians Prioritise Patient Safety but Gaps Remain: Patient Safety Poll" NolPolls, September 17, 2025. Available at https://www.noipolls.com/post/patient-safety-poll. Cited by C Onyemelukwe and Y Balogun, "Improving Clinical Governance and Patient Safety while Complying with Legal Standards: What Health Facilities Should know" Health Ethics and Law Consulting, February 02, 2026. Available at https://healthlaw.com.ng Accessed March 11, 2026 at 12:56pm.
[8] M Abubakar and M Okafor, "Nigerian Doctors Suspended over Death of Adichie's Son" reported 4th March 2026. Available at <https://www.bbc.com> accessed March 16, 2026 at 12:34 am.
[9] World Health Organisation. Patient Safety, 2026. Available at https://www.who.int/health-topics/patient-safety#=tab_1> Accessed January 27, 2026 at 1:03pm.
[10] A J R Macfarlane, "What is Clinic Governance?" (2019) *BJA Education Journal*, 19(6), Pp. 174-175.
[11] *Indian Medical Association vs V. P. Santha* (1995)
[12] *Ojo vs Gharoro* Case (n2).

the layer of the skin. This was noted by the gynecological surgeon who documented it and took the necessary step to remove the broken pieces wherein one piece was found while the other could not be found. The normal procedure for reporting such incidents was followed afterwards the patient was closed up with the remaining broken needle still inside the abdomen. Subsequently, the Appellant needed another surgery to remove the broken needle when she started experiencing pain in her abdomen. As such, she sued the Respondents for medical negligence and for damages. Regrettably, the Appellant lost the case all through from the High Court to the Supreme Court. The court adjudged that the Appellant failed to lead expert evidence to prove the level of negligence of the medical practitioner.

The Respondents in their evidence at the trial court admitted that the needle was broken and that the broken part of the needle was left in the Appellants abdomen and could not be found; although, under cross examination the Respondents called what transpired during the surgical operation an accident. The 1st Respondent testified to the effect that with the quality of surgical needles now available in Nigeria, they get easily broken. The Appellant concluded her case that the evidence of the 1st Respondent points irresistibly to one conclusion that they used of substandard surgical needle(s) in the conduct of the surgical operation on her amounted to negligence. On that piece of evidence, the Learned Justice of the Supreme Court reacted thus:

> ***"The 1st Respondent, a consultant, said under cross examination that a surgical needle is not a strong tool. It breaks or snaps easily. This worries me. It is sad that an instrument for operation of the human being is not strong enough that "it breaks or snaps easily".***[1]

Consequent upon the following premise, the Appellant based her case on the principle of *res ipsa loquitur,* which is a Latin maxim, meaning, the thing speaks for itself. Several commentators have attempted to characterize the phrase as a rule, principle, doctrine, maxim or a myth.[2] All of these concepts have been used interchangeably in several legal discourse; but in the context of this research, *res ipsa loquitur* will be used as a principle. *Res ipsa loquitur* is applicable to actions for injury by negligence where no proof of such negligence is required beyond the accident itself, which is such that necessarily involve negligence.[3]

Research[4] shows that the volume of medical negligence litigations in Nigeria is relatively low when compared to developed countries due to certain prevalent factors, such as; lack of reporting system of those incidence[5], inability to obtain medical records to support litigation such as basic information about their diagnosis and treatments,[6] difficulty in obtaining expert witness opinions to sustain a claim in medical negligence which is a specialised area of practice;[7] and financial impecuniosity to prosecute a cause of action through litigation. It is axiomatic that litigation is expensive and hiring the services of a professional lawyer to successfully prosecute a case in area that needs professional expertise is even more expensive which most victims of medical negligence may not be able to afford.

[1] Ojo vs Gharoro Case (n2) at p.227.
[2] G G Webb, " The Law of Falling Objects: Byrne vs Boadle and the Birth of Res Ipsa Loquitur" *Stanford Law Review* (2007) 59, 1065-1110 at 1065 citing G H L Fridman, "The Myth of Res Ipsa Loquitur" (1954) *U. Toronto L. J*, 10 at 233. Also, M MacGrath, "Res Ipsa Loquitur – A Rule, Principle, A Maxim, A Doctrine, A Myth or a Convenient Label? Irish Judicial Studies Journal (2024), 8(2), 67-77.
[3] *Ojo vs Gharoro* Case (n2).
[4] K Adegboyega, "Medical Negligence in Nigeria and the Obstacles to Litigation" (2023) MAAUN International Multidisciplinary Journal of Research and Innovations (MIMJRI), A Publication of the Institute of Africa Higher Education Research and Innovations (IAHERI),vol. 1, Pp. 183-196. Available at https://doi.org/10.59479/jiaheri.v1i001.27. Accessed March 11, 2026 at 10:58am.
[5] T Olofinlua, "Medical Negligence in Nigeria [Part 2]: The Slow Road to Justice" (2015) Radiant Health Magazine. Available at www.radianthealthmag.com/.../medical_negligence-in-nigeria-the-lingroad-to-justice. Accessed March 11, 2026 at 11:04am.
[6] B Odunsi, "Glancing Back at Eden: A Note on Medical Negligence in Nigeria" Public Lecture Presented at Ogun State Bar and Bench Forum, 10th Public Lecture, High Court of Justice, Abeokuta, Nigeria October 18, 2019. Cited by K Adegboyega (n16) at 189.
[7] P N J, Kassim, *Medical Negligence Law in Malaysia* (Malaysia: International Law Book Services, 2008). Cited by Adegboyega (n16) at 190.

Arising from the above stated facts, the questions begging for answers are; what remedies have the law provided to enable victims of medical negligence access justice? Secondly, to what extent has the patient-consumer concept, assisted victims of medical negligence in Nigeria? Thirdly, is the doctrine of the standard of care and informed consent a shield or a sword in medical negligence cases? Proffering answers to these questions and many more will be the interest of this research.

3. Legal Framework for Patients Safety in Nigeria

In Nigeria, there are multiple laws, regulations and regulatory bodies overseeing healthcare delivery, medical ethics and public health policy.[1] These laws and standards govern the quality of care, patient safety, and professional conduct in both public and private health facilities, namely:

i. **The Constitution of the Federal Republic of Nigeria 1999**.
   This is the primary legislation that provides for right to health and patient safety in Nigeria. Right to health,[2] dignity of human person,[3] non-human or degrading treatments,[4] privacy and personal life,[5] and informed consent[6] are intrinsically connected to right to life.[7]

ii. **Medical and Dental Practitioners Act**[8]. This Act established the Medical and Dental Council of Nigeria[9] saddled with the responsibility of regulating medical education, setting professional standards, registering and licensing practitioners as well as discipline of medical practitioners who breach the ethics of the profession.

iii. **National Health Act 2014**. This Act provides a framework for the regulation, development and management of a health system. It also set standards for rendering health services in Nigeria. Section 1 of the National Health Act establishes the National Health System, which provide a framework for standards and regulation of health services, without prejudice to extant professional regulatory laws. Furthermore, Section 2 of the Act provides for the constituent parts of the National health system and section 2(1) lists the functions of the Ministry of Health as a regulator for the sector to include: (a) ensure the development of national health policy and issue guidelines for its implementation; (b) collaborate with the states and local governments to ensure that appropriate mechanisms are set up for the implementation of national health policy; (c) collaborate with national health departments in other countries and international agencies; (d) promote adherence to norms and standards for the training of human resources for health; among other things.
   The Act is an umbrella law that regulates health system in Nigeria and establishes enforceable mechanisms that achieve patient safety.[10] The Act provides for all public and private health establishments to obtain a certificate of standards before commencing operations, reinforcing minimum quality and safety thresholds.[11] It mandates providers to take steps to ensure patient safety and quality care.[12] Health facilities are also required to comply with quality requirements issued by the National Council on Health.[13] The Act prohibits refusal of emergency medical

[1] E Odumu, "Legal Frameworks for Healthcare Infrastructure Development in Nigerian Communities: A Comparative Analysis (2024) Social Science Research Network. Available at https://papers.ssrn.com/sol3/delivery.cfm/4957749.pdf?abstractid=4957749. Accessed March 11, 2026 at 1:29pm.
[2] Section 17 CRFN, 1999.
[3] Section 34 CFRN, 1999.
[4] ibid
[5] Section 37 CFRN, 1999.
[6] *Medical and Dental Disciplinary Tribunal vs Okonkwo* (2001) LPELR-1856 (SC)
[7] Section 33 CFRN, 1999.
[8] Medical and Dental Practitioners Act, CAP M8 Laws of the Federation of Nigeria 2004 hereinafter (MDPA).
[9] Section 1 of MDPA.
[10] Basic Healthcare Provision Fund – National Health Insurance Scheme. Available at https://www.nhia.gov.org Accessed April 09, 2026 at 11:12pm. Also, Sections 13, 23 and 30 of the of National Health Act (NHA) 2014.
[11] Section 13 of NHA, ibid.
[12] Section 21(2) ibid
[13] Section 19

treatment[1] and mandates health care providers to give patients relevant information about their health status and proposed treatments.[2]

4. The Concept of Medical Negligence

The standard of care established by the Code of Medical Ethics in Nigeria requires practitioners to possess reasonable skill, knowledge and competence comparable to an average, qualified practitioner.[3] The more skilled a person is, the more care expected of him. The health care provider or medical practitioner owes a duty of care to the patient. Thus, if he undertakes to care for or treat a patient, whether there is an agreement or not, he has already put up himself as a professional in that field of practice.

It is important to emphasised that the fact that mishap occurs does not necessary amounts to negligence.[4] The law places a burden on the plaintiff or claimant to prove that the defendant was negligent. In the case of ***Otti vs Excel-C Medical***,[5] the court held thus:

> ***It is rudimentary law that in order to find a medical professional guilty of negligence, the situation has to be such that what he did is what professional colleagues would say that he really made a mistake and that he ought not to have made it. Put differently, the action must be such that falls short of the standard of a reasonably skillful medical professional.***

According to Pandit and Pandit[6], negligence has many manifestations – it may be active negligence,[7] collateral negligence,[8] comparative negligence, concurrent negligence, continued negligence, criminal negligence, gross negligence, hazardous negligence, active and passive negligence, wilful or reckless negligence or negligence *per se.*[9]

The concept of medical negligence flows from the breach of duty of care owed to a patient by a medical practitioner. In the cases of ***Laxman Balkrishna Joshi vs Trimbark Babu Godbole and another***[10] *and* ***A. S Mittal vs State of U.P***.[11] it was held that where a doctor is consulted by a patient, the doctor owes his patient certain duties, namely: duty of care in deciding whether to undertake the case, duty of care in deciding the treatment; and duty of care in the administration of that treatment. A duty of care arises when a person (doctor) or entity (hospital) has a legal obligation to ensure the safety and well-being of another person (patients).

There are key factors that establish the existence of a duty of care, namely: foreseeability[12], proximity and public policy consideration.[13] This three-prong test was established in the case of ***Caparo Industries Plc vs Dickson***[14] and followed in plethora of cases.[15] The principle of foreseeability opines that for the medical practitioner to be

[1] Section 20
[2] Section 23
[3] Rules 26 to 70 of the Code of Medical Ethics (2008).
[4] I P Enemo, (n3).
[5] (2019) 16 NWLR (Pt. 1698) 274.
[6] M S Pandit and Shobha Pandit, "Medical Negligence: Coverage of the Profession, duties, Ethnics, Case Law and Enlightened Defense – A Legal Perspective" (2009) *Indian J. Urol*. 25(3), 372-378.
[7] Active negligence involves affirmative, careless actions – doing something a reasonable person would not – rather than just omitting to act. For example, in Donogue vs Stevenson (1932) AC 562, where a manufacturer's positive act of producing a contaminated beverage caused harm to the purchaser.
[8] This is an indirect carelessness or damage that occurred during but not inherent in the performance of a contract. For example, in the case of *McDonald Egejuru vs Niger Construction Limited*, Suit No. NICN/PHC/136/2018, the court held the Defendant negligent for failing to provide adequate security at the workplace that resulted in injury to the Claimant while performing his duty.
[9] ibid
[10] (1969) SC 128.
[11] (1989) SC 1570.
[12] If a reasonable person could foresee that their actions might cause harm to someone else, a duty of care is likely to arise. M McLachian, "Understanding Negligence: A Guide to Foreseeability" (2015) Journal of Legal Studies, 1-12.
[13] O Deb, "Medical Negligence and Consumer Protection Act" (2024) *International Journal of Advanced Research (IJAR)* 12(9) Pp. 1464-1471at 1466.
[14] (1990) 2 AC 605.
[15] *Anyah vs Imo Concorde Hotels Ltd* (2002) 18 NWLR (Pt. 799) 377; *UTB Ltd vs Ozigi* (1994) 3 NWLR (Pt. 333) 385;

held liable for negligence, it must be determined whether a professional in that field would have foresaw the harm as a reasonable consequence of the action. This does not mean that the medical practitioner must foresee every harm resulting from his medical action.[1] The standard is that of a reasonable man in that field. When a medical practitioner breaches the duty of care owed to patient automatically medical negligence is said to have arisen. Secondly, proximity in the context of the rule refers to the relationship that have been established to exist between the parties to create a duty.[2] Third party interest are excluded that is, where there is no direct relationship liability will be lie. The public policy consideration is where the court will decline to hold a medical practitioner liable on grounds of fairness, justness and reasonableness in order not endanger or undermine the professional medical services rendered.

Another important principle in medical negligence is that of informed or implied consent. This simply means full disclosure of information made by the healthcare provider as a duty of care to the patient.[3] It applies that medical practitioner provide a patients with all the information and choices they need to decide for themselves as part of clinical trials.[4] For the consent to be valid, there are four basic requires under the law that must be fulfilled, namely: the medical practitioner must made full disclosure of the nature of the sickness; the procedure involved in the treatment; explain comprehensively the risk or benefits to the understanding of the patient in clear and simple terms; and the patient must have the mental capacity to understand and take an informed decision. That is, the individual must be of sound mind, mentally capable of understanding the information and consequences of their decision and the decision must be made freely without coercion or manipulation or pressure.[5]

However, there are exceptions to the general rule where prior consent may be waived. For example, in a situation of emergency, a scenario that may jeopardise the life of the patient because he / she is unconscious or unable to communicate immediately and immediate action is needed to save life. Secondly, it may also be waived where the patient is a person below the age of maturity.[6] In the case of ***Otti vs Excel-C Medical Centre Ltd***,[7] the Appellant visited the Respondent for medical treatment and a surgery was performed on him that resulted in permanent injury as a result of complications. The Appellant's claim was dismissed on the grounds of failure to call expert witness because a judge cannot guess what constitute medical negligence and non-discharge of the burden of proof. The court held that unsuccessful treatment does not automatically equal to medical negligence

Similarly, it is now recognized that a medical practitioner may withhold certain information from a patient where he believes that disclosing same to the patient may cause him or her serious physical or mental harm.[8] This legal principle is called therapeutic privilege.[9] According to Lord Denning[10]:

> ***A medical man, for instance, should not be found guilty of negligence unless he has done something of which his colleagues would say: "He really did make a mistake there. He ought not to have done it" … but in a hospital, when a person who is ill goes in for treatment, there is always some risk, no matter what care is used. Every surgical operation involved risks. It would be wrong, and, indeed, bad law, to say that simply a***

Abubakar vs Joseph (2008) 13 NWLR (Pt. 1104) 307; and *Okwejiminor vs Gbakeji* (2008) 5 NWLR (Pt. 1079) 172.

[1] *Ter Neuzen vs Korn* (1995) 3 S.C.R. The Supreme Court of Canada held that a medical practitioner is not required to foresee every specific or remote harm; *Palsgraf vs Long Island Railroad Co*., 248 N.Y. 339, 162 N.E. 99 (1928) where it was held that the court must avoid bias and do not expect practitioners to anticipate every rare or idiosyncratic harm.

[2] Caparo vs Dickman (n46). However, in the case of *Alcock vs Chief Constable of South Yorkshire Police* (1992) 1 AC 310that principle has been extended now to accommodate proximity in time and space to the shocking event.

[3] Section 23 and 24 of the NHA (n28).

[4] H Fatima, "Informed Consent and Medical Law" (2023) *International Journal of Law and Management and Humanity,* 6(6), Pp. 147-159 at 147.

[5] Sections 23 and 24 National Health Act, LFN 2014.

[6] *Otti vs Excel-C Medical Centre Ltd* (n36)

[7] ibid

[8] *Reibi vs Huges* (1980) 2 S.C.R. 880, The Supreme Court of Canada held that a judge may be justified for withholding or generalizing certain information where the patient's emotional or psychological state makes them unable to cope with full disclosure.

[9] *Sideway vs Board of Governors of Bethlem Royal Hospital* (1985) AC 871; *Medical and Dental Practitioners Disciplinary Tribunal vs Okonkwo* (2001) 7 NWLR (Pt. 711) 2026 and Section 23(3) of the NHA (n28).

[10] Lord Denning, *The Discipline of Law* (London: Butterworth's Publishers, 1979.) Pages 237 - 243

> ***misadventure of mishap occurred, the hospital and the doctors are thereby liable. It will be disastrous to the community, if it were so... you must not therefore, find him negligent simply because something went wrong… you should only find him guilty of negligence when he fails short of the standard of a reasonably skilful medical man, in short, when he is deserving of censure."***

In the case of ***Canterbury vs Spence***,[1] It was held that this principle applies only to when disclosure would so severely upset the patient as to foreclose rational decision-making, and the burden is on the doctor to justify it.

5. Standard of Proof in Medical Negligence and the Evolution of the Principle of *Res Ipsa Loquitur*

The standard of proof in medical negligence in civil claim is basically on the preponderance of evidence or balance of probabilities. This is done by proving three main cardinal principles, namely: there existed a duty of care, breach of the duty of care, and that the breach directly caused the patient injury.[2] Notwithstanding this general principle that the burden of proving negligence lies squarely on the claimant who must established the above stated principles, there are instances where a party can invoke the principle of *res ipsa loquitur* to prove a case of negligence.

The principle of *res ipsa loquitur* in medical negligence flows from the principle of negligence *per se.* The Black's Law Dictionary defines negligence *per se* as "Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is a violation of statute or valid municipal ordinance or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. In the Indian case of ***Poonam Verma vs Ashwin Patel and Ors***[3] the Supreme Court of India held a doctor who does not have knowledge of a particular system of medicine but practice in that field as a quack and guilty of negligence *per se.*

Res Ipsa Loquitur is a common law principle established in the case of *Byrne vs Boadle*[4] where a barrel of flour fell out of a warehouse window and struck a man named Byrne. He could not proof why the barrel fell but relied on the fact that the barrel could not just fall and cause injury without negligence. The court per Baron Pollock held that some accidents does not just happened without negligence.[5] *Res ipsa loquitur* is a rule of evidence affecting the onus of proof. The essence of the maxim is that an event which in the ordinary course of things, was more likely than not to be caused by negligence was by itself evidence of negligence depending of course on the absence of explanation. The principle merely shift the onus of proof on the defendant. Reliance on the principle is a confession that the Plaintiff or Claimant does not have a direct or affirmative evidence as to the defendant negligence but that the surrounding circumstances amply establish such negligence.[6]

Generally, the principle of res *ipsa loquitur* is interpreted to mean an inference drawn when an injury is sustained showing an act of negligence in the situation different from a natural cause of event which allowed the burden of proof to shift to the defendant in favour of the plaintiff.[7] The application of this principle raises two presumptions, namely: that the event that resulted in injury to the plaintiff was caused by a breach of duty of care owed to the plaintiff and by the defendant.[8] There must be reasonable evidence of negligence. But where the thing is shown to be under the management of the defendant or his servants, and the accident is, such as, in the

[1] 464 F.2d 772 (D.C. Cir. 1972)
[2] *Bolam vs Friern Hospital Management Committee* (1957) 1 WLR 582 and Otti vs Excel-C case (n38)
[3] (1996) 4 SCC 322.
[4] *Byrne vs Boadel*, 159 Eng. Rep. 299, 299-300 (Exch. 1863).
[5] *Ibid*
[6] *Management Enterprises Ltd vs Otusanya* (1987) 2 NWLR (Pt. 55) 179; *Barkwa vs South Wales Transport* (1950) 1 All ER 392
[7] Ighreriniovo vs SCC (Nig) Ltd (2013) 10 NWLR (Pt. 361) 138. The Supreme Court of Nigeria held that for the burden to shift three main conditions must be fulfilled, namely: the instrument causing the damage must be under the exclusive control of the defendant, the occurrence must be such that it ordinarily would not happen without negligence and the absence of an explanation as to how the accident occurred.
[8] *Ojo vs Gharoro Case (n2).*

ordinary course of things does not happen if those who have the management, use proper care. It affords reasonable evidence, in the absence of explanation by the defendant that the accident arose from want of care.[1]

In an action for negligence against a professional person in connection with his calling, the question for consideration by the court is whether on a balance of probabilities it has been established that the defendant failed to exercise the care required of a man possessing and professing special skill in circumstances which require the exercise of that special skill. *Res ipsa loquitur* is applied when a patient suffers an injury or harm that is unforeseeable even with the exercise of proper care and the medical provider's negligence is the most probable cause.[2] For *res ipsa loquitur* to apply, the event which gave rise to the negligence must tell its own story and it must invariably be a clear and unambiguous story of lack of duty of care.[3]

The fulcrum of the case of *Ojo vs Gharoro* at the Supreme Court was whether the Respondents rebutted the presumption of *res ipsa loquitur* that the Respondent were negligent. The court resolved the issue in favour of the Respondents on the grounds that only the Appellant gave evidence and did not discharge the burden of proof for it to shift to the Respondents.[4] The court concluded thus:

> ***In a complicated and highly professional case such as this, where she relies on the doctrine of res ipsa loquitur, arising from abdominal operation, I expected her to call expert evidence and here I have in mind surgeon or surgeons.***[5]

In arriving at this conclusion, the Supreme Court relied and quoted with approval the English case of ***Mahan vs Osborne***[6] where the defendant performed an emergency abdominal operation on one Thomas Mahan. During the operation, swabs were used to pack off adjacent organs from the area of the operation. About three months after the operation the patient became seriously ill, and when operated on, it was found that a swab had been left in his abdomen at the first operation which resulted in his death. The Supreme Court of Nigeria quoted Lord Scott L.J. thus:

> ***… it is difficult to see how the principle of res ipsa loquitur can apply generally to actions for negligence against a surgeon for leaving a swab in a patient, even if in certain circumstances the presumption may arise. If it applies generally, plaintiff's counsel, having by couple of answers to interrogatories proved that the defendant performed the operation and that a swab was left in, would be entitled to ask for judgment, unless evidence describing the operation was given by the defendant. Some positive evidence of neglect of duty is surely needed. It may be that a full description of the actual operation will disclose facts sufficiently indicative of want of skill or care to entitle a jury to find neglect of duty to the patient. It may be that expert evidence in addition will be requisite. But to treat the maxim as applying in every case where a swab is left in the patient seems to me an error of law.***

Similarly, the Supreme Court cited the cases of ***Highston vs Jost***[7]***, Fish vs Kapur***[8]**,** and ***Roe vs Ministry of Health***.[9] All to the effect that it is not enough to invoke and rely on the principle of *res ipsa loquitur* without prove by witness(s) particularly expert witness. This conclusion was predicated on the principle of law that:

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[1] Clerks and Lindsell, Torts, 13th Edition (London: Sweet and Maxwell, 1969) at 568-569.
[2] S Aggarwal, "The Evolution of Res Ipsa Loquitur in Modern Medicolegal Practice" (2024) *International Journal of Legal Science and Innovation*, 6(1) Pp. 46-50 at P.47.
[3] Ibid
[4] Per Tobi JSC in Ojo vs Gharoro (n2) at 229 Paras. E.
[5] Per Tobi JSC in Ojo vs Gharoro (n2) at 229 Paras. E.
[6] (1939) 2 KB 14 or (1939) 1 All ER 535
[7] (1943) 1DLR 402 where sodium Penthathol was injected intravenously and leaking into surrounding tissue. It was held that res ipsa loquitur does not apply.
[8] (1948) 2 All ER 176, where a dentist extracted a tooth, leaving part of root in jaw and fracturing jaw, the court held res ipsa loquitur not to apply.

> ***… in an action for negligence, against a professional person in connection with his calling, the question for consideration by the court is whether on a balance of probabilities it has been established that the defendant failed to exercise the care required of a man possessing and professing special skill in circumstances which require the exercise of that special skill.***[1]

From the judgment in the case of ***Ojo vs Gharoro***, it is important to reiterate that the principle of *res ipsa loquitur* is premised or predicated on the mere fact of an event happening, which is based on two rebuttable presumptions, namely: that the event happened as a result of a duty of care somebody owes his neighbor and that that somebody is the defendant. It is difficult to agree with the above line up of authorities relied upon by the Supreme Court of Nigeria in the above stated case.

Rather, I will strongly align with the reasoning in the case of State of **Haryana & Ors vs Smt. Santra**[2], where the principle of *res ipsa loquitur* was successfully raised to hold a medical practitioner liable for medical negligence. In this case, a mother of seven children underwent a family planning - sterilization operation (tubectomy) in a government hospital sponsored by the State. The medical doctors performed the surgical operation on one fallopian tube leaving the second one untouched this resulted in the patient being pregnant and giving birth to the eight child. The medical doctor was held liable for medical negligence.

Applying this reasoning to the case of ***Ojo vs Gharoro***, this researchers argue that the act of leaving a piece of broken needle in the body of the Plaintiff / Appellant said it all where ordinarily the principle of ***res ipsa loquitur*** should have been invoked and upheld. This is because for ***res ipsa loquitur*** to apply, from the evidence and contention of the Respondents, it was established that substandard needle was used for the medical operation and the needle got broken and left in the abdomen of the Appellant; although, they argued that the needle was broken accidentally.[3] It is our view the mere fact that substandard surgical needles was used raises a presumption that the respondents owed the plaintiff / Appellant the duty of care to have been even more cautions not to allow the needle to be broken knowing the medical implication of allowing an extraneous particle in the human body.

6. Current Standard of Proof of Medical Negligence

The law and practice of medical negligence has moved away from what was obtainable in the case of *Ojo vs Gharoro*. Traditionally, medical practitioners liable was to consider whether the medical practitioner breached his duty of care to a patient. In arriving at this position, it must be ascertain that the medical practitioner failed to exercise the requisite skill-set in a situation of reasonable degree which he claims to possess that resulted in damages to the patient.[4] In the *locus classicus* case of ***Bolam vs Friern Hospital Management Committee***,[5] Bolam was suffering from mental illness of the depressive type and was advised by the Doctor attached to the defendants' hospital to undergo electro-convulsive therapy. Prior to the treatment, Bolam signed a consent form but was not warned of the risk of fracture involved, even though the risk was very small. Bolam received the treatment but did not sustained any fracture at the first treatment but repeated treatment resulted in fracture. The court held that the medical practitioner involved was not negligent because the expert opinions were divided as to the use of relaxation drugs and manual control of the risk of the operation. It was held that in the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion and the doctor is not negligent merely because his conclusion differs from that of other professional men.[6]

Presently, Medical negligence is actionable under the Consumer Protection Act as a "deficiency in service" when healthcare provider fails to act with reasonable skill or care, causing injury. Patients can claim compensation for negligence – such as wrong treatment, retained instruments, or lack of informed consent. This

[9] (1954) 2 QB 66 where the plaintiff was operated on in the defendant hospital and a spinal anesthetic of nupercaine was administered by the defendant. After the operation, plaintiff developed spastic paraplegia resulting in paralysis from the waist. The doctrine of res ipsa loquitur was held not applicable.
[1] Ashcroft vs Mersey Regional Health Authority (1983) 2 All ER 245.
[2] (2000) 5 SCC182; or 2000 (3) CPJ 8(SC).
[3] *Ojo vs Gharoro* (n2) at 224-225 paras H-G and at 235 Para.E.
[4] *Bolam Case (n53).*
[5] ibid
[6] *Bolam Case (n53).*

new approach is to enable patients to access justice through patient-consumer concept which has widened the doctrine of standard of care and informed concept under our laws. This new normal which involved the reclassified of the doctor-patient relationship to that of service provider and consumer relationship renders deficiency in service actionable. In ***Indian Medical Association vs V.P. Shantha***[1], It was held that:

> ***Service rendered to a patient by a medical practitioner (except where the doctor renders service free of charge to every patient or under a contract of personal service), by way of consultation, diagnosis and treatment, both medicinal and surgical, would fall within the ambit of 'service' as defined in Section 2(1) (o) of the Act.***

This decision is in line with the United Nations Guidelines for the Protection of Consumers which are sets of international principles that provide a blueprint for governments to develop and strengthen consumer protection laws. The guidelines were first adopted by the General Assembly in in 1985[2]. The journey started on the 23 day of July 1981, when the Economic and Social Council made resolution requesting the Secretary General to continue consultations on consumer protection with a view to elaborate a set of general guidelines for consumer protection, taking into particular account the need for developing countries. Objective number 1(c) of the 1985 resolution[3] encouraged high level of ethical conduct for those engaged in the production and distribution of goods and services to consumers. Article 3(a) provides for the protection of consumers from hazards to their health and safety, Article 3(c) provides for access to consumers to adequate information to enable them to make informed choices according to individual wishes and need and Section 3(e) provides for availability of effective consumer redress. On the strength of the above stated resolutions, several countries enacted their consumer protections laws. For the purpose of this research, that of Nigeria, India and the United Kingdom will be considered.

By the incursion of the Consumer Protection laws into medical practice, the position held in the case of *Ojo vs Gharoro* where the case was thrown out for failing to call expert witness(s) to prove medical negligence has been watered down and may no more hold sway. For example, *in* ***Kishan Rao vs Nikhil Super Speciality Hospital***[4], where the wife of the complainant who suffered from fever and chills was taken to the Respondent hospital for treatment. For four days she was mistakenly treated for typhoid rather than malaria. The incorrect treatment resulted in her death. The Supreme Court of Indian upturned the decision of The Indian National Consumer Redressal Commission (NCDRC) that dismissed the case on the ground that no expert witness was called held thus:

> ***…no mechanical approach can followed by these fora. Each case has to be judged on its own facts. If a decision is taken that in all cases, medical negligence has to be proved on the basis of expert evidence, in that event the efficacy of the remedy provided under this Act will be unnecessarily burdened and in many cases such remedy would be illusory.***[5]

This decision upturned the earlier judgment entered in the case of ***Martin F. D'Souza vs Mohammed Ishfaq***[6], to the effect that medical expert opinion was a mandatory requirement for success in medical negligence claim. The court indirectly reaffirmed the principle of *res ipsa loquitur* that where the negligence is obvious to a "reasonable

[1] (1995) SCC (6) 651
[2] Resolution 39/248 of 16 April 1985, later expanded by the Economic and Social Council in resolution E/1999/INF/2/Add.2 of 26 July 1999, and recently revised by the General Assembly in resolution 70/186 of 22 December 2015.
[3] United Nations Guidelines for Consumer Protection, Resolution 39/248 of 106th Plenary Meeting, 9/4/1985, Thirty-ninth Session, Supplement No. 51(A/39/51) at p. 179-181 The United Nations Guidelines for Consumer Protection was further expanded in 1999.
[4] (2010) 5 SCC 513.
[5] ibid
[6] (2009) 3 SCC 1.

man"[1], such as leaving a swab in a body[2], wrong blood transfusion[3], or a clear misdiagnosis or mistreatment of a common ailment[4] and permit me to say forgetting broken surgical needle on the body of a patient as in the case of *Ojo vs Gharoro* does not need an expert opinion. The reasoning of the court was that victims cannot be burdened with the high cost and difficulty of finding an expert doctor who will be willing to testify against a colleague while the medical practitioner or hospital hides behind procedural technicalities where there is clear "deficiency in service."

Applying this current position to Nigeria, the coming into force of the FCCPA in its definition section interprets a consumer to broadly include recipient of services.[5] This failure to provide service is considered as a professional misconduct which allows patients to seek compensation for such failed transaction.[6] Accordingly, the relationship between a healthcare provider and a patient is a commercial transaction involving provision of services as the medical practitioner duties of consultations, surgeries, test and treatment are all services rendered to the patient as consumer. Section 130(1)[7] FCCPA provides thus:

> ***When an undertaking agrees to perform any service for or on behalf of a consumer, the consumer has a right to –***
>
> ***a. The timely performance and completion of those services, and timely notice of any unavoidable delay in the performance of the services;***
> ***b. Performance of the services in a manner and quality that reasonable persons are generally entitled to expect;…***

This implies that services rendered by a service provider (medical practitioner) will be done reasonable care and skill. This position is buttress by the provision of Section 142(3)[8] which provides thus:

> ***In a contract for the supply of a service where the supplier is acting in the course of a business, there is an implied term that the supplier will carry out the service with reasonable care and skill.***

This section create a legal duty on every provider of services in Nigeria to render their services free of defects in line with applicable standards[9] in the course of performing their duties. This is regardless of the fact whether there was a written contract between the parties because there is an implied warranty of quality.[10]

In the case of ***Adepoju Anuoluwapo Olufunmilayo vs FCCPC***[11], the court held that patients are consumers of medical services and they should be protected from negligence and substandard care. Similarly, in the case of ***Premier Specialist Hospital vs Ugboma***,[12] where Peju Ugboma, a Lagos based pastry chef, underwent an elective surgery (hysterectomy) at Premier Specialist Hospital in May 2021. The surgical operation was successful. However, the family alleged that post operation surgery negligence resulted in complications that led to her death. The hospital was held liable by the FCCPC for deficiency in service and sanctioned.

The legal implication of this new normal is the strict adherence of medical service providers to establish standard protocols as even informed consent by the patient (client) will not exonerate them from liability. In Nigeria, the

[1] In the *Locus Classicus* case of *Vaughan vs Menlove* (1837) 132 E. R. 490.
[2] *Mahun vs Osborne* (1839) 2 K.B. 14; or 1 All E.R. 535.
[3] *Medical and Dental Practitioners Disciplinary Tribunal vs Okonkwo* (2001) 7 NWLR (Pt. 711) 206. Also, *Post Graduate Institute of Medical Education and Research vs Jaspal Singh* (2009) 7 SCC 330 where a patient with an 'A' Rh-positive blood group was mistakenly transfused with 'B' positive blood, leading to their death. The hospital was held liable for medical negligence. Similarly, the case of *Cassidy vs Ministry of Health* (1951) 2 KB 343.
[4] *Kishan Rao Case (n77)*, where the complainant wife who had fever and chills was wrongly treatment of typhoid that resulted in her death. The hospital was held liable.
[5] Section 167(1) of FCCPA ibid.
[6] Otti vs Excel-C Medical Case (n36).
[7] Section 130 of the Federal Competition and Consumer Protection Act (FCCPA) LFN, 2018.
[8] ibid
[9] Section 131 of the FCCPA.
[10] Section 130 of the FCCPA.
[11] Unreported case in Suit No. FHC/L/CR/125C/2020
[12] Inquest into the Unfortunate Death of Peju Ugboma (2023). Available at https://fccpc.gov.ng Accessed April 08, 2026 at 2:42pm.

shift toward treating patients as "consumers" of healthcare services has strengthened the requirement for informed consent[1] and increased the accountability of medical institutions. The National Health Act has revolutionalised healthcare services, in Nigeria from professional ethical guideline to a statutory obligation. By Section 23[2] every health care provider must inform a patient of their status, the range of diagnostic procedures and treatment options available, the health benefits, risks and consequences associated with each option. The patient right to refuse treatment and require clear explanation of the medical implication is guaranteed by law.[3] However, the patient consent can be waived in instances where the patient is unable to give consent and a person authorized by law can give the consent. It can also be waived where waiting for the consent will result in serious public health risk, death or irreversible damage.[4]

Secondly, the standard of prove of medical negligence is to some extent lowered. That is, all that is required of the complainant is to prove deficiency in service without necessary going into the professional arena of proving medical negligence without requires technicality and expert witness. Although expert witness may still be needed in certain cases but it is not a fundamental requirement of law to prove culpable of a medical practitioner[5] especially in circumstances where the principle of *res ipsa loquitur* can be invoked. Thirdly, there is institutional accountability where the hospital can be held vicariously liable for administrative failures such as lack of functional or substandard equipment that lead to a deficiency in service even where the individual medical practitioner exercise due diligence or care.[6]

7. Cross Country Analysis

Healthcare delivery is a universal necessity, yet, the legal frameworks governing medical negligence remain deeply fragmented across different jurisdiction. While some countries adopt a strict liability model, others view the standard of professional duty adopted in Bolam's case as the best model to balance professionalism and the necessity of providing health needs. There is another framework that considered effective redress by way of compensation for injured patient as a way of healthcare sustainability. To understand this position, it is important to juxtapose the practice of medical law in Nigeria and what is obtainable in India and the United Kingdom.

7.1 Medical Negligence in India

In the Indian case of ***Samira Kohli vs Dr. Prabha Manchanda***[7], the standard of care and the doctrine of informed consent was examined *vis-a-vis* the impact of those concept on the rights of patients to seek accountability and compensation for substandard medical care.[8] The Appellant a 44 year old unmarried woman visited the Respondent – a medical doctor and gave consent for diagnostic purposes over prolonged menstrual issues. The Respondent ended up performing a surgical operation that resulted in the removal of the patient's uterus. Upon being sued by the Appellant, the medical doctor argued that he obtained consent from the patient's mother who was waiting outside to perform the surgical operation. It was held that the consent given by the patient for diagnostic purpose cannot be stretched by the surgeon to include additional surgery. Consequently, the medical doctor was held liable for medical negligence for failure to obtain informed consent from the patient.[9]

Balram Prasad vs Kunal Saha[10] This was a case of allegation of medical negligence that resulted in the death of the wife of the Respondent. The summary of the fact is that the wife of the Respondent a child Psychologist had

[1] Section 115 of FCCPA.
[2] Section 23 of National Health Act (NHA), 2014.
[3] Section 23(1)(c) of NHA, 2014.
[4] Section 24 of NHA, 2014.
[5] *V. Kishan Rao Case (n71).*
[6] For example, in *Igbokwe vs University College Hospital Board of Management (1961) WRNLR 173* where the hospital was held liable for the death of a patient diagnosed of suspected case of psychosis following a childbirth. The deceased was treated and a nurse was instructed by a doctor on duty to keep an eye on her. Regrettably, the nurse assigned to keep an eye on the deceased left her duty post which resulted in the fall and death of the deceased.
[7] (1997) 6 SCC 241.
[8] O Deb, "Medical Negligence and Consumer Protection Act" (2024) *International Journal of Advanced Research (IJAR)*, 12(9), Pp. 1464-1471.
[9] *Samira Kohli* (n98).
[10] (2014) 1 SCC 384.

skin rash which was later diagnosed to be Toxic Epidermal Necrolysis and was treated by the Appellant and others. It was alleged that her death was due to administration of excessive doses of long-acting steroids and the lack of proper supportive care. The Supreme Court of Indian found in favour of the Respondent for the death of his wife and awarded compensation against the Appellants and ordered stricter action against negligent medical established and recommended the enactment of a law to regulate private hospitals and nursing homes.

Kusum Sharma vs Batra Hospital & Medical Research Centre[1]; Kusum Sharma filed a complaint following the death of her husband who was diagnosed abdominal tumor suspected to be malignant. Surgery was conducted that led to removal of the spleen (splenectomy) that resulted in multiple surgeries and complications. The Supreme Court of India dismissed the case that the doctors were not negligent. It was held that medical science is not an exact science, a surgeon's choice between two recognised methods does not constitute negligence just because it failed or resulted in complications.

In the case of ***Indian Medical Association vs V. P. Shantha & Ors***[2], the definition of service to include healthcare services offered by medical practitioners to be covered by Section 2(1) of the Consumer Protection Act of India came up for determination. This was a representative action for compensation for medical negligence against several patients. It was contended that medicine is a profession and the relationship between doctors and patients are that of personally service, not trade or commerce to be regulated by the Consumer Protection Act. The Supreme Court held thus:

In the case of ***V. Kishan Rao vs Nikhil Super Speciaility Hospital & Anor,***[3] the wife of the complainant who suffered from fever and chills was taken to the Respondent hospital. For four days, she was mistakenly treated for typhoid instead of malaria that resulted in her death. The decision of the District Court awarding damages was upheld by the Supreme Court. It was held thus:

> ***…no mechanical approach can followed by these fora. Each case has to be judged on its own facts. If a decision is taken that in all cases, medical negligence has to be proved on the basis of expert evidence, in that event the efficacy of the remedy provided under this Act will be unnecessarily burdened and in many cases such remedy would be illusory.***

In the case of ***Martin F. D'Souza vs Mohammed Ishfaq,***[4] the Respondent suffered from chronic renal failure and was undergoing treatment at a hospital where the appellant was the doctor. It was alleged that due to the doctor's negligence, specifically regarding the dosage of an antibiotic (Amikacin) and the failure to conduct necessary blood tests – he suffered permanent hearing loss (ototoxicity). The Supreme Court upturned the decision of the National Consumer Disputes Redressal Commission of India. The court held that:

> ***A medical practitioner is not liable for negligence simply because things went wrong or because a different procedure might have been better. A doctor is only liable if their conduct fell below the standard of a reasonably competent practitioner in that field. A doctor cannot be held liable for every unsuccessful treatment. The medical profession has to be left to the doctors; a judge cannot take over their role."***

The court went ahead to state that where there is an allegation of medical negligence, the matter should be referred to a competent medical practitioner or medical committee for evaluation and report of a prima facie case of medical negligence before instituting a case against a medical practitioner.

Arun Kumar Manglik vs Chirayu Health and Medicare Private Ltd[5] the case involved the death of Madhu Manglik who was admitted for dengue fever. The patient suffered a cardiac arrest and died 24 hours after admission. The case alleged that the hospital failed to follow the World Health Organisation (WHO) standard

[1] (2010) 3 SCC 480; AIR 2010 SC 1050.
[2] (1995) SCC (6) 651.
[3] (2010) 5 SCC 513.
[4] (2009) 3 SCC 1.
[5] (2019) 7 SCC 401; 2019 INSC 43.

protocols for monitoring dengue patients. The court held that failure to monitor a patient's progression and providing timely treatment is a clear breach of duty of care as such compensation was awarded.

The case of ***Bombay Hospital and Medical Research vs Asha Jaiswal***,[1] involved the death of Dinesh Jaiswal who was admitted for abdominal aortic aneurysm. Complications arose after a surgery leading to lack of blood flow to the lower limbs. There was failure of a diagnostic machine which delayed a critical test and a follow up re-exploration surgery could not be done because all operation theatres were occupied for 12 hours. The Supreme Court of Indian dismissed the appeal and held that technical failure of malfunctioning of a medical machine and the unavailability of operation theatres does not amount to medical negligence as such the principle of res ipsa loquitur does not apply.

A similar position was maintained in the ***Chanda Rani Akhouri vs M S Methusethupathi***,[2] where in November 1995, the husband of the appellant underwent a transplant and the surgery was deemed successful. However, there was complications such as infections and neurological issues that resulted in the death of the patient in February of 1996. The appellant alleged that the death of the patient was as a result of post-operative medical negligence and a failure in follow-up care. The court held that the duty of a medical practitioner is to provide reasonable care and skill and not to guarantee a specific outcome as such a doctor will not be held liable because he could not save the life of a patient. The standard of proof set out in Bolam's case was adopted and reiterated to exonerate the doctor.

In the case of *Jacob Mathew vs State of Punjab*, the patient who was admitted in a hospital had difficulty in breathing. A doctor was called upon and he responded after 20-25 minutes and connected an empty cylinder of oxygen to the mouth of the patient which caused the breathing difficulty to increase and the death of the patient.[3] Following a criminal complaint was made against the medical practitioner for negligent an investigation was carried out and a charge proffered against the medical practitioner. The Supreme Court of Indian held thus:

> ***The investigating officer and the private complainant cannot always be supposed to have knowledge of medical science, so as to determine whether the act of the accused medical professional amounts to rash or negligent act within the domain of Criminal Law under Section 304-A of the Indian Penal Code. The criminal process once initiated subjects the medical professional to serious embarrassment and sometimes harassment… we may not be understood as holding that doctors can never be prosecuted for an offence of which rashness or negligence is an essential ingredient. All that we are doing is to emphasise the need for care and caution in the interest of society; for service, which the medical profession renders to human beings, is probably the noblest of all and hence there is need for protecting doctors from frivolous or unjust prosecution.***[4]

The court went further to set down the following guidelines for prosecution of a medical practitioner for medical negligence:

> ***Statutory Rules of Executive Instructions incorporating certain guidelines need to be framed and issued by the Government of India and or the State Governments in consultation with the Medical Council of India. So long as it is not done, we proposed to lay down certain guidelines for the future which should govern the prosecution of doctors for offences of which criminal rashness or criminal negligence is an ingredient. A private complaint may not be entertained unless the complainant has produced prima facie evidence before the court in the form of a credible opinion***

[1] (2021) SCC 1149; 2021 INSC 801.
[2] (2022) SCC 481.
[3] B V Subrahmanyam, *Medical Jurisprudence and Toxicology* (Allahabad, India: Law Publishers, 2011) Pp. 651-675
[4] B V Subrahmanyam, "Jacob Mathew vs State of Punjab, the Judgment Stipulates the Guidelines to be followed Before Launching a Prosecution against a Doctor for Negligence." (2013) *Journal of Neurosciences in Rural Practice*, 4(1), Pp. 99-100

> ***given by another competent doctor to support the charge of rashness or negligence on the part of the accused doctor. The investigating officer should before proceeding against the doctor accused of rash or negligent act or omission, obtain an independent and competent medical opinion preferably from a doctor in government service qualified in the branch of medical practice who can normally be expected to give an impartial and unbiased opinion in regard to the facts collected in the investigation …***[1]

In the final analysis, in India, a doctor is considered not negligent simply because a treatment failed or a better alternative existed. As long as the doctor followed an acceptable standard of practice in the particular case. The law does not require the highest possible level of expertise, but it strictly frown at the exercise of care and skill below what is expected of a medical practitioner in that particular situation. Consequently, from the above number of cases, it is safe to say that there is a balanced legal framework on medical law in India that protects patients' rights both as a tortuous and as a consumerist right from genuine malpractice while on the other hand shielding medical practitioners from unwarranted harassments from unfavourable medical outcomes. [2] Meanwhile, performing a medical procedure without an informed consent of explaining the risks, benefits and alternatives to the patient in a clear and simple language, generally will amount to medical misconduct.[3]

7.2 Medical Negligence in the United Kingdom

It will seem difficult to raise and maintain an action for medical negligence in Britain despite the number of cases of medical accidents.[4] The courts are reluctant to interfere in clinical matters, because "it would be a mistake to think of doctors and hospitals as easy targets for the dissatisfied patient"[5]. Medical negligence in the UK is governed by key legal principles principally centred on standard of care and informed consent. It is the interest of this segment to look at the issue of medical negligence in the UK through the cases.

In ***Bolitho vs City and Hackney Health Authority***,[6] the A two year old boy suffered serious respiratory collapse while in the hospital failure to respond to him immediately resulted in cardiac arrest, severe brain damage and subsequent death. It was argued that the death would have been averted if there was prompt attention and respond to the patient. The court modified the Bolam test to the effect that not in all cases that a body of medical expert opinion will exonerate a medical practitioner. According to the court for the body of medical opinion to be acceptable it must be satisfied that the opinion has a logical basis. The implication of this case is that the body of expert opinion must be merely a professional consensus or a shield of a professional colleague from an irrational practice. This position was followed in the case of ***Tarrant vs Monkhouse***.[7] The logical justification test is examined in accordance with contemporaneous medical records and the informed consent principle.[8]

Montgomery vs Lanarkshire Health Board,[9] the patient a pregnant woman with diabetes was admitted in the hospital for vagina delivery. During child birth, the child suffered shoulder dystocia that resulted in serious complications including cerebral palsy due to oxygen deprivation. It was in evidence that when the patient raised concerned about the size of her baby the medical practitioner did not disclosed the possibility shoulder dystocia because the patient would have opted for a caesarian session was not in the best interest of the patient. The doctor was held liable for medical negligence. The court established the fact that the law has shifted towards

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[1] B V Subrahmanyam, (n95)
[2] S V Kulkarni, "Medical Negligence – The Judicial Approach by Indian Courts" (2003) *Indian Journal of Surgery,* 65(6), Pp. 500-505. Available at <https://asiindia.org> Accessed April 10, 2026 at 3:07pm.
[3] D Harish and A Singh, "Medical Negligence Laws in India: Legal Guide for Doctors" (2009) *Journal of Indian Academy of Forensic Medicine*, 31(1), Pp. 52-59.
[4] Jackson and Powell, Professional Liability, 9th Edn. (London: Thomson Reuters Westlaw Books, 2026) Chapter 13
[5] ibid
[6] (1998) AC 232; (1997) 4 All ER 771.
[7] (2025) EWHC 2576 (KB). The Claimant, a paramedic, brought a negligence claim against a bariatric surgeon following complications after a gastric sleeve operation and a subsequent balloon dilatation procedure. The court dismissed the claim. The court criticized a medical expert opinion for failing to provide coherent rationale for their opinion.
[8] Ebanks-Blake vs Calder (2025) EWHC, where the career of a professional footballer ended prematurely as a result of orthopedic surgery conducted on his ankle. The defence of the medical practitioner supported by experts to the effect that failure to perform the arthroscopy would actually have been negligent was overruled as not being reasonable nor logical.
[9] (2015) AC 1430; (2015) 1 All ER 1031.

patient autonomy regarding informed consent. The focus in the case was not what the doctor thought as important but what a reasonable patient would want to know before agreeing to a procedure. The court held that a doctor is under a duty to take reasonable care to ensure that patient is aware of any material risks involved in recommended treatment and any reasonable alternative or variant treatment. The court went further to state that the issue of informed consent is no longer covered by a patient merely appending signature to a document. There was be a meaningful dialogue between the medical practitioner and the patient covering all reasonable alternatives even if they believe that the alternative is less ideal than the recommended treatment.

In **Paul vs Royal Wolverhampton NHS Trust**[1] family members sought damages for psychiatric injury after witnessing a relative's death from heart attack caused by a prior failure to diagnose his life-threatening heart condition 14 months after. The Supreme Court dismissed the claim that the NHS Trust was not liable for the psychiatric illness suffered by the family member. The court held that witnessing a medical crisis resulting from a previous failure to treat does not qualify as medical negligence because the medical practice is not an event. The court went further to state that extending doctor's liability to family members who witness a death of their relatives would impose an unreasonable and unfathomable burden on the healthcare system.

In the UK medical negligence is primarily governed by the law of negligence as a civil wrong under Tort or as a criminal wrong. Consumer protection laws principally governed by the Consumer Rights Act[2] provides for accountability for health care services. However, medical negligence is not treated as a consumer complaint under the UK Laws. The principle laid down in the Bolam case is still holds sway in the UK. That is, to succeed in the case of medical negligence, the complainant must prove breach of duty of care and causation – that the breach directly caused the harm.

Under the UK Consumer Rights Act, patients have specific rights alongside their rights to sued for negligence. Section 49 provides that service rendered must be performed with reasonable care and skill. Interestingly, anything aid or written to the patient by the healthcare provider about the service can become a binding contractual term if the patient relies on it. However, a medical practitioner is excluded from using the contract terns whether written or oral to exclude liability for death or injury resulting from negligence. The consumer protection approach in the UK is more applicable private health practitioners and private patients whom the Most importantly, there the position seems to move towards out of court settlement approach in cases of medical negligence with the medical practitioner would have been found culpable.[3]

8. Recommendations

i. The Oronsaye report tied medical negligence to lack of equipment and infrastructure which is as a result of lack of funding of the health sector by government. Consequently, there is need to increase funding to the health sector to enable provision of improved healthcare services which will in turn reduce medical negligence.

ii. There is need to strengthen patient care regulation – "patient-centric" approach to enforce rights-based pursuit involving consumer protection and statutory law, in addition to and apart from individual practitioner professional regulation in Nigeria. This means the standard of care is not just about what the doctor thinks but the treatment or service provided must align with established global and medical guidelines or protocol for that particular service provided.

[1] (2024) UKSC 1; (2024) 1 All ER 757.
[2] UK Consumer Right Act, 2015.
[3] CCC vs Sheffield Teaching Hospitals (2023) UKSC 5, the claimant, a child, suing by her mother and litigation friend sought damages for lost of years of earnings due to life-shortening injuries. The Trust admitted liability for the injury and the court awarded 100% compensation by reaffirming the principle of restitution in integrum. Similarly, in Maisha Najeeb vs Great Ormond Street Hospital for Children NHS Trust (Unreported case number: TLQ/12/0817) Maisha Najeeb, a minor suffered from Arteriovenous Malformation (AVM) and she underwent a medical embolisation procedures which involves medical glue and contrast dye. The surgeon mistakenly injected permanent glue instead of medical dye into the 10-year old girl's brain causing catastrophic damage. The hospital trust admitted full liability and compensation settlement was reached. Also, in Milly Evans vs NHS (Reported case Number: HQ10X01683), due to failure to monitor heart rate properly during child labour, the result was the child born with severe brain damage. The claim was admitted and compensation reach.

iii. There is need to strengthened the FCCPC to carry out their core mandate in compliance with product safety standards in service delivery.

iv. There is need to established a health policing agency to monitor medical malpractice and negligence by examining and reviewing all medical services or procedure resulting in death or permanent disability.

9. Conclusion

The medical profession occupies a noble and indispensable position in society, as it is entrusted with the sacred duty of preserving human life. As Lord Denning[1] aptly observed, every surgical operation carries inherent risks, and it would be unjust and detrimental to public interest to hold medical practitioners liable for every mishap or unsuccessful outcome. Protecting doctors from frivolous or vexatious claims remains essential to encourage the fearless practice of medicine.

Nevertheless, the realities of medical practice in Nigeria reveal a disturbing pattern of avoidable harm and, in some cases, outright negligence. High-profile incidents, such as the death of young Nkanu Adichie-Esege in January 2026[2] following complications at a private hospital in Lagos, underscore the urgent need for greater accountability. The traditional doctor-centric approach, exemplified by the Supreme Court's decision in *Ojo vs Gharoro*, often placed insurmountable evidentiary burdens on patients — requiring expert testimony even in cases where negligence appeared self-evident, such as a broken surgical needle left in the abdomen.

Happily, Nigerian law has begun to evolve. The recognition of patients as consumers of healthcare services under the Federal Competition and Consumer Protection Act (FCCPA) 2018 represents a significant paradigm shift. By reframing the doctor-patient relationship as one of service provider and consumer, the law now treats substandard care as a "deficiency in service." This patient-centric approach has lowered procedural barriers, strengthened the application of the doctrine of res ipsa loquitur in obvious cases, reinforced the requirement of informed consent, and promoted institutional accountability for hospitals.

While this development enhances patients' access to justice and aligns with global consumer protection standards, it must be applied judiciously. Courts and regulators should continue to strike a careful balance: shielding competent and diligent practitioners from undue litigation, while ensuring that victims of genuine negligence receive meaningful redress. The pendulum must not swing too far toward therapeutic immunity at the expense of patient rights, nor should it descend into a climate of defensive medicine that ultimately harms healthcare delivery.

Achieving this equilibrium demands complementary reforms: increased public investment in healthcare infrastructure and equipment, stricter enforcement of quality standards, capacity-building for the Federal Competition and Consumer Protection Commission (FCCPC), and the possible establishment of a dedicated mechanism for rapid review of serious medical incidents. Ultimately, a robust patient-centric framework under consumer protection law, harmonised with professional regulation, will not only deter negligence but also foster greater trust in Nigeria's healthcare system and uphold the constitutional right to dignity and quality healthcare.

[1] Lord Denning, *The Discipline of Law* (n52).
[2] M Abubakar and M Okafor (n8).