MEDICAL MALPRACTICE IN NIGERIA: EXPLORING ALTERNATIVES TO THE TORT SYSTEM



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ABSTRACT

In Nigeria, obtaining compensation and justice for medical negligence claims is hindered by the current adversarial system, which fails to provide fair and equitable outcomes for patients and healthcare practitioners. The traditional tort-based fault system contributes to systemic inefficiencies in the healthcare sector, obstructing access to justice and discouraging the open disclosure of medical errors. Globally, restorative justice frameworks and no-fault compensation systems have emerged as viable alternatives to address these challenges. Restorative justice and the no-fault system foster a more equitable and transparent medico-legal system by prioritising systemic learning, patient-centred compensation processes, and reconciliation over punitive measures. This thesis critically evaluates and compares the no-fault compensation model utilised in New Zealand, Sweden, Denmark, and the United States, assessing its suitability for Nigeria's legal and medical frameworks.

Furthermore, the study explores the potential application of restorative justice concepts, emphasising communication, healing, and systemic learning as alternative methods for resolving medical disputes within Nigeria's institutional, cultural, and legal contexts. This thesis also explores Ubuntu, an Indigenous African philosophy that underscores human dignity, communal responsibility, and reconciliation as a guiding principle for developing an appropriate medico-legal dispute resolution system in Nigeria. Methodologically, this study employs policy analysis of current healthcare regulatory frameworks, qualitative case studies of medical negligence issues in Nigeria, and comparative legal analysis of

global best practices. Consequently, this thesis proposes an integrated model of Ubuntu, restorative justice, and a no-fault scheme for resolving medical negligence disputes. It elucidates how this interdisciplinary approach can enhance healthcare accountability in Nigeria by balancing professional responsibility, patient safety reforms, and equitable compensation. It presents a roadmap for legislators, legal experts, and healthcare regulators to implement institutional and legislative changes that will transform Nigeria's medico-legal landscape and ensure an equitable, effective, and enduring process for resolving medical negligence cases.

DEDICATION

This thesis is dedicated to the memory of my beloved late brother, Adewale Akinsola Adeyemo, and to all those who have lost their lives due to medical negligence in Nigeria.

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First, I give all glory to Jesus Christ, my Lord and Saviour, the source of my strength, wisdom, and endurance, upon which I have relied throughout this journey. I acknowledge His infinite mercy, which has upheld me through victories, struggles, and untold stories along this path.

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ACA	Arbitration and Conciliation Act
ACC	Accident Compensation Corporation
AIDS	Acquired immunodeficiency syndrome
AHRQ	Agency for Healthcare Research and Quality
AMA	Arbitration and Mediation Act
ARJS	African Restorative Justice System
ATJLF	Africa Transformational Justice Legacy Fund
BHSS	Basic Health Services Scheme
CARe	Community Apology and Resolution
CANDOUR	Communication and Optimal Resolution
CEO	Chief Executive Officer
CHC	Comprehensive Health Centres
CRPs	Comprehensive Health Centres
Enl.	Enlarged
HCS	Health Clinics
HDC	Health and Disability Commission
IRLJ	International Review of Law and Jurisprudence
LPELR	Law Pavillion Electronic law Report
MAAUN	Maryan Abacha American University of Nigeria
MDPIP	Medical and Dental Practitioners Investigation Panel

MDPA	Medical and Dental Practitioners Act
MDPDT	Medical and Dental Practitioners Disciplinary Tribunal
NHIS	National Health Insurance Scheme
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICA	Neurological Injury Compensation Association
NMAACA	Nigerian Medical Accidents Accountability and Compensations Act
NMAACCO	Nigerian Medical Accidents Accountability and Compensations Commission
NPHCDA	National Primary Health Care Development Agency
NWLR	Nigerian Weekly Law Report
NZQHS	New Zealand Quality of Healthcare Study
PBoR	Patients' Bill of Rights
PHC	Primary Health Centres
PPP	Public-Private Partnerships
PT	Part
Qual	Quality
Rev.	Revised
RJ	Restorative Justice
Saf	Safety
S Afr JPhilos	South African Law Journal
SAN	Senior Advocate of Nigeria

SAP	Structural Adjustment Programme
Soc Sci Med	Social Science and Medicine Journal
Surg.	Surgery
UCH	University College Hospital
UCH	Universal Health Coverage
UNIZIK	Nnamdi Azikiwe University
United States	United States of America
WACA	West African Court of Appeal
WCC	Workers' Compensation Commission
WHO	World Health Organisation
WRN	Weekly Report of Nigeria
WWJD	What will Jesus Do

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INTRODUCTION

In Nigeria, patients who have experienced medical negligence may seek redress through different legal avenues available through the tort system or statutes. Tort law in Nigeria is based on the common law system and requires a patient to prove that medical practitioners breached the standard of care. However, the Nigerian tort system is costly for patients, physicians, and the government because of the intensive litigation process, which is fault-based and time-consuming. Additionally, aggrieved claimants can pursue arbitration, conciliation, and mediation provided for under the Nigerian Health Insurance Authority Act 2022 (the Act),[1] and arbitration and mediation can also be pursued under the more general Arbitration and Mediation Act 2023 (AMA).

However, arbitration still requires the patient to establish fault on the part of the practitioner, and although conciliation and mediation do not involve binding determinations, because these processes are in the 'shadow of the law,' whether the patient could establish fault through the tort system will have a material influence on how, if at all, disputes are resolved through these processes. In addition, The Medical and Dental Practitioners Act 1988 (MDPA) allows disciplinary procedures to be taken against medical practitioners, but this legal avenue does not provide redress to patients. In this thesis, I will argue that none of these systems meets the needs of the patients in terms of redress and that other approaches, including no-fault schemes and restorative justice, should be

[1] s. 47

explored to improve the current options for obtaining medical negligence redress in Nigeria.

The tort system in Nigeria has several challenges, including forensic difficulties in proving 'fault' and court delays in processing cases of medical negligence. For example, patients must face the costs of hiring a lawyer and going through the litigation process, often accompanied by procedural delays and psychological and emotional impacts. Further, the tort system discourages physicians from owning responsibility when incidents occur, as they seek to protect their reputations against claims filed by patients to avoid stigmatisation. This results in the practice of defensive medicine, which weakens the healthy patient-doctor relationship and ignores the safety of patients. In their discussion of defensive medicine in Europe, Garatini & Padula purported that 'defensive medicine includes all medical actions that physicians do without considering them the standard of care according to their clinical knowledge; these actions are meant to shield best physicians from negligence or malpractice lawsuits filed by patients or their families.'[2]

Additionally, patients' search for information has been ignored when they file for claims, usually enduring long periods awaiting trial. Often, this results in psychological and emotional consequences for both patients and physicians. This notion has been supported by Gutheil et al. who stated that 'a body of research has argued that litigation can have a destructive emotional impact on its participants.'[3] Thus, there is a need to improve the

[2] Livio Garattini and Anna Padula, 'Defensive medicine in Europe: a 'full circle'?' (2020) 21(2) The European Journal of health Economics 165.

[3] Thomas G Gutheil and others, 'Preventing "Critogenic" Harms: Minimizing Emotional Injury from Civil Litigation' (2000) 28(1) Journal of Psychiatry & Law 5.

medical negligence system to provide adequate redress to patients, improve their safety, and ensure the accountability of medical practitioners.

I recognise the ongoing debate by legal scholars and practitioners on upholding the 'moral superiority of faults standards' by proponents of the tort system. For example, Ernest Weinrib[4] and Andrew Burrows[5] argue that the principles of fairness and justice are embedded in the fault standard, as defendants are liable only when their conduct has been objectively proven to be careless. However, the standards have been critiqued by leading scholars from the bar and bench, such as Prof. Patrick Atiyah,[6] as having its limitations, such as the impossibility of meeting the 'objectivity' threshold leading to arbitrary outcomes. Including where the patient, for instance, has been harmed without any fault on the part of the physicians and its overall ineffectiveness and inefficiency where the physicians have 'tactically' and conveniently protected themselves from being held liable. Notwithstanding, for a clime like Nigeria, where patients are culturally non-litigious, the standards for proving harm to patients are realistically unachievable.

Concerns about the impact of medical negligence systems on patients and medical practitioners have been discussed internationally. [7]Changes have primarily focused on reforming the tort system or a replacement with a no-fault system adopting alternative models. However, Nigeria and similar sub-Saharan African countries still lag in designing

[4] Ernest Weinrib, *Tort Law* (London, Routledge, 2018).

[5] Andrew Burrows, *Understanding the law of obligations: essays on contract, tort and restitution* (Hart Publishing 1998)120.

[6] Peter Cane and PS Atiyah, *Atiyah's Accidents*, *Compensation and the Law* (7th Edn, Cambridge University Press 2006), See also Baroness Hale in Greggs v. Scott [2005] UKHL 2; See also Margaret Fordham. 'Loss of—A lost Opportunity? Gregg v. Scott' (2005) Singapore journal of legal studies 204

[7] David H Sohn, 'Negligence, genuine error, and litigation' (2013) 6 International Journal of General Medicine 49; Nancy Fadling, 'Candour: At the Heart of Patient Safety,' (2017) Journal of Health Care Finance <www.healthfinancejournal.com> accessed 10 March 2023.

a medical negligence system that can provide adequate redress for patients in healthcare. Hence, it is pertinent that healthcare systems in countries like Nigeria and similar jurisdictions look beyond the financial and temporal concerns of both patients and medical practitioners. They should focus on reparation, reconciliation or apology, and restitution. Consequently, adopting restorative practice as a guiding principle will aid the implementation of the alternative avenues provided under the Act. There are reasons to believe that a restorative approach will resonate with the Nigerian healthcare system due to its relational and indigenous values.

Nigeria is a larger Indigenous community with several ethnic and cultural groups that share a common philosophy of justice termed 'Ubuntu' in African literature. Mbiti defines this as 'a communitarian thesis of I am because you are, and because you are, therefore, I am.'[8] This analogy describes the true African Justice system, which is based on the principles of restoration and forgiveness. Thus, there is a need to explore how indigenous dispute resolution methods can be utilized within the healthcare setting in Nigeria to address patient safety incidents. Therefore, this research argues for a redesign of the current alternative system through the adaptation of a collaborative and relational framework based on restorative approach principles and the adoption of a no-fault system to compensate patients who experience harm without having to show 'fault' considering the Nigerian context.

[8] John S. Mbiti, African religions & philosophy (2nd rev. and enl. edn, Heinemann 1990).

The development of alternative models to accessing justice is critical to healthcare reform in Nigeria because of the inadequacy of the existing fault-based system. My study's primary concern is that the extant system makes it difficult for patients who have experienced medical negligence to access justice and/or compensation and do so within a reasonable time. Hence, should the no-fault system be adopted to meet the needs of patients? Will this resolve most of the complications and inadequacies of the fault system? Will this help prioritise the interests of patients' safety and accountability from the health care providers? Consequently, the central claim of my research is that the no-fault system and the embedded principles and philosophy of a restorative approach can potentially solve many of the complications and inadequacies of the current system in Nigeria.

Based on these considerations, the proposed research examines whether the legal framework for accessing compensation for medical negligence can be improved for patients in Nigeria. This work examines key research questions outlined below:

1. What should be the goals of Nigeria's legal framework for redressing patients who have experienced medical negligence?
2. Could Nigeria's tort and/or court system be reformed to achieve these goals better?
3. Could Nigeria's current dispute resolution and redress legislative system be improved?
4. How have successful alternative models to the tort system been developed in other jurisdictions?
5. Could a no-fault System with an embedded restorative approach infused with Ubuntu facilitate better redress for patients than the tort system in Nigeria and existing alternative models? How might it work in practice?

To address these essential questions, I will explore the operation of the fault system in Nigeria through an analysis of Nigerian legislation and case law, which is heavily dependent upon the British common law system. This thesis evaluates the National Health Insurance Authority Act 2022, which makes provisions for alternative models such as mediation, conciliation, and arbitration, my argument is that these provisions do not prioritise the interest of patients, given the procedural complexities (such as those in the AMA) associated with these models.

In addition, I will explore the existing alternative models by comparing them to how successful alternative models to the tort system have been developed in other jurisdictions with gold standards for these alternatives, such as New Zealand, Sweden, Denmark, and the United States. This will contribute to the literature and inform the lack of research on the barriers to implementing alternative models in Nigeria. In terms of the no-fault system, its international context through a comparative analysis of its practice or operation and legislation in Nigeria will be examined extensively. At the core, I will expound on how the no-fault and restorative justice system will increase the accountability of medical practitioners and ensure patients' safety.

Furthermore, I will review and examine case laws and legislation on medical negligence in Nigeria, which were decided by the Nigerian courts to expose the inadequacy of the tort system. By doing this, I seek to establish a tripartite point by (i) the underlying reason(s) why claims against medical negligence are not pursued, (ii) describing how difficult it is to prove fault in the pursuit of claims, and (iii) indicating and analysing how the system

has adversely led patients who have experienced medical negligence to withdraw or abandon their claims in court under the current tort system. Overall, I will argue how the no-fault and restorative justice systems will increase the accountability of medical practitioners to ensure patients' safety and ultimately reduce the incidence of medical negligence in the Nigerian health care system.

This thesis adopts a multi-method research design, encompassing both (a) doctrinal research specific to Nigeria and (b) Comparative legal research focused on jurisdictions with gold standards that have adopted the no-fault and restorative justice systems.

Doctrinal research – will provide a detailed assessment of common law practice of compensating claims for medical negligence, legal statutes, subordinate legislations, and case law in Nigeria. Additionally, I will explore the legal frameworks and legislation, such as the Nigerian Health Insurance Authority Act 2022, which proposes using alternatives to litigation but fails to explore whether a no-fault system could address the inadequacies of the fault-based system operative in Nigeria.

Comparative research approach – Here, the operation of exclusive and non-exclusive no-fault systems in New Zealand, Sweden, Denmark, and the United States is evaluated.[9] This is to determine how the no-fault model can be successfully integrated and operated into Nigeria's medical negligence system and how the current alternative models can be improved.

[9] Some of these are common law countries and/or have similar legal history with Nigeria.

The wholistic output of this thesis relies on an extensive review and cross-analysis of existing literature, with a solid premise on the work of Obafemi Komolafe and Ireh Iyioha. Komolafe examined the present law and practice regarding medical negligence litigation in Nigeria.[10] He argues for redress for victims through a new alternative dispute resolution system and calls for a total healthcare system reform and proposed a Model Medical Negligence Act for Nigeria.

Other scholars[11] have also proposed the creation of new systems that are informal and involve the active participation of the parties (patients, medical practitioners, and the community). Additionally, Iyioha[12] explores the NHIS Act, 2005 (now repealed), as an attempt to improve the state of healthcare in Nigeria. Iyioha attempts to evaluate the tort system in Nigeria and the no-fault system in New Zealand and Sweden. Whereas these previous works set the tone for alternative model advocacy, this proposed work will look at exploring culturally conscious alternatives to resolving medical negligence disputes in Nigeria, for example, Ubuntu. It also seeks to ascertain barriers to the implementation of existing mechanisms for dispute resolution and what appropriate recommendations could be made for the improvement of the medical malpractice system in Nigeria.

[10] Akinlabi Richard Obafemi Komolafe, 'Medical Negligence Litigation in Nigeria: Identifying the Challenges and Proposing a Model Law Reform Act' (PhD thesis, College of Dublin 2017).

[11] SS Tri Herlianto, 'Constructing Penal Mediation on Medical Malpractice Cases: A Restorative Justice Perspective' (2014) 24 Journal of Law and Policy 9; Neels Claassen, 'Mediation as an alternative solution to mediation malpractice court claims' (2016) 9(1) South African Journal of Law and Bioethics 7; Lego Karjoko, et al., 'The Urgency of Restorative Justice on Medical Dispute Resolution in Indonesia' (2021) 16 (2) Journal of Law & Social Studies 362; Rudy Sapoelete et al. 'The Concept of Penal Mediation for the Crime of Medical Negligence in Realizing Legal Protection for Medical Personnel and Patients or Their Families' (2021) 8 (2) International Journal of Multicultural and Multireligious Understanding 147.

[12] Ireh Iyioha, 'Medical Negligence and the Nigerian National Health Insurance Scheme: Civil Liability, no-Fault or a Hybrid Model?' (2010) 8(1) African Journal of International and Comparative Law 46.

Consequently, this work proposes that a no-fault and restorative justice system be made mandatory and implemented as an alternative approach to the litigation (tort) process in medical negligence in Nigeria. This will provide the opportunity for patients' interests to be prioritised and ensure patients' safety and medical practitioners' accountability. This approach is novel regarding scholarly research on medical negligence in Nigeria and the adoption and implementation of the no-fault system as a legal framework. It will also consider whether a no-fault system in Nigeria through a restorative approach in the healthcare setting is suitable for medical malpractice and whether it would compensate victims, ensure healthcare providers' responsibility and accountability, and promote justice within the healthcare setting.

CHAPTER ONE

CRACKS IN THE NIGERIAN HEALTHCARE SYSTEM: THE GENESIS OF MEDICAL NEGLIGENCE

1.1 Introduction

Evidence suggests that the quality of individuals' health directly influences the economic landscape of any society.[13] Therefore, every country aiming for economic growth should not neglect its health sector, as it is crucial for national development. Notably, healthcare systems that guarantee access to and provide quality services and patients' safety must be prioritised, safeguarded and decentralised.

Africa's healthcare system, especially Nigeria, faces numerous challenges hindering equitable access to quality care. These challenges originate from several factors: infrastructural, human, and capital resources, as well as socio-economic and regulatory issues. Despite being the Giant of Africa[14] and the most populous Black nation with a growing population of over 200 million people,[15] Nigeria struggles with both an underfunded public health sector and a limited private health sector which serves the wealthier demography.[16] Healthcare in Nigeria grapples with unique difficulties due to

[13] Clare Bambra and others, 'Health for Wealth: Building a Healthier Northern Powerhouse for UK Productivity'(2018) Northern Health Sciences Alliance, Newcastle <www.thenhsa.co.uk/app/uploads/2018/11/NHSA-REPORT-FINAL.pdf> accessed 1 September 2024.

[14] AlexReports, 'Shameful!!! See African Countries whose passports rank above Nigerian passport' (2022) <www.abujapress.com/2022/03/shameful-see-african-countries-whose.html> accessed 1 September 2024.

[15] Worldometer, 'Nigerian Population (LIVE)'< https://www.worldometers.info/world-population/nigeria-population/> accessed 1 September 2024.

[16] Ajovi Scott-Emuakpor, 'The Evolution of Health Care Systems in Nigeria: Which Way Forward in the Twenty-First Century' (2010) 51(2) Nigerian Medical Journal 53, <www.ajol.info/index.php/nmj/article/view/59866> accessed 12 August 2024.

limited resources, overburdened healthcare services, an ever-growing shortage of healthcare professionals and complex socio-cultural dynamics. Other difficulties are sometimes due to inconsistencies in policy, under-enforcement of existing regulations, and frequent political instability. These factors adversely impact the quality of healthcare services and exacerbate incidents of medical negligence and access to justice for those failed by the healthcare system.

This chapter discusses the overall state of the Nigerian healthcare system – its genesis and associated factors contributing to the rising cases of medical negligence. Without shifting the focus from individual errors of medical practitioners, the realities of systemic and individual errors cumulating into medical negligence, which affect the health outcomes of patients, are explored. By examining these systemic and individual issues, the shortcomings of the tort system in resolving and obtaining justice regarding medical negligence claims in Nigeria are also conceptualised. Further, it also asserts the urgent need for reform and presents a case for overhauling and improving current means of resolving medical negligence disputes. Subsequent chapters will build upon this foundation by proposing alternative models, such as restorative justice (RJ) and no-fault models, for resolving and providing more effective solutions to medical negligence claims or disputes in Nigeria.

1.2 Evolution of the Nigerian Healthcare System

Healthcare in Nigeria continues to evolve from predominantly indigenous practices to a combination of both conventional (Western) and traditional practices.[17] From pre-colonial to post-colonial Nigeria, the healthcare system has undergone significant transformations indicative of today's reforms, which are influenced by colonial legacies.[18]

1.2.1 The Pre-colonial Era

Before colonialism, health remedies were predominantly based on herbal medicine, also known as traditional medicine. Many people used herbal medicine and diviners to address their medical concerns; for example, using medical concoctions to treat snake bites or measles or using metaphysics (superstitions) to address childhood killer diseases, rituals and sacrifices to cure perceived spiritual afflictions, among others.[19] During this period, health was perceived as a form of spiritual warfare that required spiritual rituals, as there were no pieces of scientific evidence to back those traditional remedies. As a holistic domain, indigenous medicine encompassed social, psychological, spiritual, and physical health issues alongside medical conditions. Traditional healers- often spiritual leaders or herbalists- played a crucial role in diagnosing and treating ailments, by utilising both spiritual interventions and natural treatments derived from plants and herbs.[20]

[17] Iroju Opeyemi Anthony, 'Understanding the Nigerian Healthcare Delivery System: A Paradox of Preventive Medicine Since the Colonial Epoch' (2019) 34 (3) International Journal of Tropical Disease & Health 1.

[18] Scott-Emuakpor (n 16).

[19] Anthony (n 17).

[20] Scott- Scott-Emuakpor (n 16).

Traditional medicine in Nigeria emphasises community responsibility for health and well-being despite variations in ethnic practices – families and communities merge expertise and resources to address common concerns and support the sick rather than embracing individualism.[21] Regardless of the ethnic group one belonged to, healthcare was closely linked to cultural and spiritual customs, with the community acting as a check on medical professionals where medical errors and carelessness occur.[22] However, some authors have argued that the traditional system was fraught with a high mortality rate, resulting from improper dosages in herbal concoctions, unsterilised instruments used in male and female genital mutilation, and superstitions that led to the deaths of many children due to perceived spiritual attacks, prompting urgent intervention influenced by Western practices.[23] However, this does not diminish the effectiveness of traditional healers in caring for their patients.[24]

Despite facing challenges related to documentation and the lack of scientific evidence to justify their methods, traditional medicine remains relevant in present-day Nigeria. Recently, Iyiola *et al*. reported that traditional medicine or healthcare systems possess advantages that Western medical systems in Nigeria often lack, such as trust, accessibility,

[21] These traditional medical practitioners were known by different appellations in different ethnic groups. For example, amongst the Yorubas, they were known as the Onisgun or Babalawo. For the Igbos, the traditional healers were referred to as the Dibias; D.D.O Oyebola, 'Traditional Medicine and its practitioners among the Yoruba of Nigeria: A classification' (1980) 14 (1) Social Science & Medicine. Part A: Medical Psychology & Medical Sociology, 23 <www.sciencedirect.com/science/article/pii/S0271712380906781> accessed September 5, 2024.

[22] Anthony (n. 17).

[23] Ibid.

[24] Muhammed Raji Modibbo and others, 'Maganin Gargajiya: Assessing the Benefits, Challenges, and Evidence of Traditional Medicine in Nigeria' (2024) 16 (10) Cureus <https://pmc.ncbi.nlm.nih.gov/articles/PMC11479391/pdf/cureus-0016-00000071425.pdf> accessed 10 January 2025.

and cultural significance.[25] While operational resources disfavoured traditional practices, the lack of accessibility, patient-to-practitioner trust and relatability remain cardinal to appropriate care.

1.2.2 Colonial Era

When Christian missionaries first arrived in Nigeria in the mid-1800s, they established the first hospitals and clinics primarily in the southern region.[26] This marked the beginning of Western medicine in Nigeria. The label 'priority patients' was introduced in those facilities. 'Priority patients' referred to the colonial administrative class and the missionaries themselves. With this term being introduced, this means that Indigenous or locals received limited and inconsistent services through mobile clinics and community dispensary outposts. According to Anthony, the 'colonially designed healthcare system was often seen as antithetical to the cultural practices of the people,' resulting in low patronage of Western medical services and significant under-utilisation.[27]

However, in the early 20th century, under British colonial rule, the Nigerian government formalised the provision of medical services. The colonial government introduced a centralised health system, to create a more organised healthcare system,[28] Along with several meaningful initiatives, this health policy primarily focused on smallpox and

[25] Adams Ovie Iyiola, K. Munir, Adegoke Wahab, 'Herbal Medicine Methods and Practices in Nigeria' in S.C Izah, M.C Ogwu and M. Akram (eds), Herbal Medicine Phytochemistry, Springer International Publishing, (Springer International Publishing 2024) 1395–1428.

[26] Anthony (n 17) 4.

[27] Ibid 3.

[28] Adedamola Adetiba and Enocent Msindo, 'Chiefs and Rural Health Services in South-Western Nigeria, c. 1920-c. 1950s' (2002) 35 (2) Social History of Medicine: The Journal of the Society for the Social History of Medicine 589.

malaria, which were major public health concerns. However, such policy vibrantly operated in densely populated urban areas, particularly Lagos, and catered to colonial officials and the native population who were directly employed by the colonial administration.[29] This bias led to poor healthcare access for the impoverished majority, especially in rural regions where many Nigerians reside.[30]

The Ministry of Health was established to coordinate the delivery of health services across the country to ensure equitable distribution of health services. Following this, the University College Hospital (UCH)[31], the nation's premier tertiary and higher health institution, was established to be an extension of the Faculty of Medicine and Teaching Hospital at the University of Ibadan.[32] Anaemene observed that UCH was critiqued for operating as a centre for curative medicine rather than as a preventative and primary care institution.[33]

On the other hand, the colonial healthcare system was characterised by racial segregation and class system, with the elites (Africans and Europeans) receiving better treatment.[34] In addition, the healthcare workforce predominantly comprised European doctors and nurses, with few provisions for the training of native healthcare providers, and consisted of few

[29] Ilesanmi Akanmidu Paul, 'A Historical Evaluation of the Prospects and Challenges of Nigeria's Health Sector, 1960-2016' (2020) 2 West Bohemian Historical Review, 201-224 <https://naos-be.zcu.cz/server/api/core/bitstreams/a21e3d2c-abbe-4af2-ab57-e5402e8b65d1/content> accessed 15 January 2025.

[30] Vitalis Nwashindu, Ambrose Onu and Uche U. Okonkwo, 'How public is public health?': A historical appraisal of public health services in colonial Enugu-Nigeria, 1917-1960' (2023) 20 Cogent Arts & Humanities 1.

[31] UCH, located in Ibadan, is still in operation to date.

[32] Benjamin Uchenna Anaemene, 'Health Sector Reforms and Sustainable Development in Nigeria: A Historic perspective' (2016) 18 (4) Journal of Sustainable Development in Africa 50.

[33] Ibid 53.

[34] Nwashindu (n 30).

hospitals and clinics which were distant to the locals.[35] The fragmented and underfunded system that Nigeria currently endures underpins a history of unequal healthcare provision. Nevertheless, the colonial era introduced medical education, public health initiatives, and the establishment of a healthcare infrastructure that would later form the basis of post-independence healthcare policies in Nigeria, formalising Western medicine leading to Nigeria's independence.

1.2.3 Post-colonial Era

Nigeria gained independence on 1 October 1960, marking the end of colonial rule. Consequently, this independence brought the promise of a healthcare system that was not only equitable but also accessible to the average Nigerian. Despite these early hopes, the healthcare system has struggled to meet these expectations. In 1962, the Nigerian Government established the first National Development Plan to promote social and economic development, which was intended to run from 1962 to 1968;[36] however, it was interrupted by coups and the civil war.[37] This led to the introduction of a Second National Development Plan between 1970 and 1974, which focused on providing quality and equitable healthcare to Nigerians.[38] Due to inadequate implementation, the policy impacted only 25% of the national population. Following this setback, the government

[35] Adetiba and Msindo (n 28).

[36] Anaemene (n 32).

[37] The civil war lasted from 1967 to 1970, halting many projects geared toward the country's development and severely straining the health system. These projects had been planned to foster advancement in health and economic terms, but the immediate consequences of the civil war, such as the number of casualties and displaced persons to be catered to, altered the plans in the first National Development Plan of 1962. See also Historical Context of Nigeria and National Economic Planning (31 March 2024) <www.umass.edu/economics/book/export/html/429> accesses 1 February 2025; Ibid (n 17).

[38] This plan had five goals to create – (1) a free and democratic society; (2) a just and egalitarian society; (3) a united, strong, and self-reliant nation; (4) a great and dynamic economy; and (5) a land of bright and full opportunities.

introduced the Basic Health Services Scheme (BHSS) as part of the Third National Development Plan (1975-1980), aiming to increase the proportion of the population accessing healthcare services to approximately 40%,[39] representing the first significant post-independence reform.[40]

The BHSS established clinics and health centres closer to local communities in rural areas to decentralise healthcare provision and relieve the pressures of overcrowding in urban areas.[41] Despite this significant leap, the scheme was undermined by shoddy execution, inadequate financing, and a breakdown in cooperation among the federal, state, and municipal administrations.[4242] Subsequently, the Structural Adjustment Programme (SAP) was introduced under the then Head of State, General Ibrahim Babangida, and continued until 1990.[43] Within this framework, the cost of healthcare surged in government-owned facilities, leading to the rise of private care facilities that were unaffordable for most Nigerians.[44]

Similarly, the Health Development Plan was implemented from 2004 to 2008 under the democratic leadership of President Olusegun Obasanjo. From 2010 to 2015, President

[39] Anthony (n 17).

[40] The objectives of the Third National Plan were to initiate the provision of adequate and effective health facilities and care for the entire population; correct imbalances in the distribution of health infrastructure for all preventive and curative care; provide the infrastructure for all preventive health services, such as control of communicable diseases, family health, environmental health, nutrition, etc; and to establish a healthcare system best adapted to the local conditions and to the level of health technology.

[41] The Fourth and Fifth National Development Plan happened between 1981-1985 and1987-1991, respectively. The Fourth National Development Plan still emphasised the BHSS and the adoption of the primary health care plan and the creation of a national health policy in 1988 occurred during the Fifth National Development Plan; Anaemene (n 32) 55.

[42] Anthony (n 17) 5.

[43] Ibid.

[44] Scott-Emuakpor characterised the development and reforms happening between 1975 to 1980 as part of the Third National Development and the Fourth National Development Plan to have occurred between 1981 to 1985, as well as the Five-year Strategic Plan from 2004-2008 targeted at achieving provision for nationwide healthcare delivery; Ibid.

Goodluck Jonathan introduced the Primary Healthcare Under One Roof Plan. From 2016 to 2023, President Muhammadu Buhari's administration developed three distinct health plans: the Revitalisation of Primary Health Care for Universal Health Coverage Plan, the WHO Revised Third Generation Nigeria Country Cooperation Strategy Plan, and the National Strategic Health Development Plan.[45]

Despite government efforts to make healthcare accessible and efficient through various reforms, these initiatives have not achieved their intended impact due to persistent underfunding, poor governance, and corruption. Although many primary healthcare facilities in rural areas were constructed, they lacked basic infrastructure, essential pharmaceuticals, and trained personnel. Consequently, Nigeria's healthcare system remains severely disjointed and underdeveloped, rendering it incapable of adequately serving the nation's rapidly growing population, as the policy objectives and actual outcomes are not aligned.

1.3 The Structure of the Nigerian Healthcare System

The failings of the post-independence healthcare reforms led to the establishment of a three-tier healthcare system designed to enhance the quality of care. The National Health Act 2014 categorises these three tiers- primary, secondary, and tertiary- managed and implemented by local, state, and federal governments, respectively.[46] Nevertheless, private

[45] Joseph Abiodun Balogun, *The Nigerian Healthcare: Pathway to Universal and High-Quality Health Care* (1st edition, Springer International Publishing AG 2022) 50.

[46] Iroju Olaronke et al., 'Interoperability in Nigeria Healthcare System: The Ways Forward' (2013) 5 (4) International Journal of Information Engineering and Electronic Business 16.

healthcare providers are permitted to operate within this framework.[47] The private sector has now become a lifeline for many due to the poor quality of care offered in public facilities. However, this comes at a cost that is often unaffordable for the average Nigerian.[48]

1.3.1 Primary Healthcare

The services offered at this level are intended to include immunisations, maternity and child healthcare, and treatment for common ailments. Local governments are responsible for operating primary healthcare facilities organised through wards, health districts, and health centres; however, these facilities often suffer from a shortage of skilled staff and inadequate resources, especially in rural areas where access to healthcare is already limited. Nonetheless, the state government also plays a role in regulating and providing technical support for basic healthcare.[49] The BHSS was the initial effort to establish primary healthcare. This scheme created three tiers of healthcare facilities, namely: (1) Comprehensive Health Centres (CHC) serving communities of over 20,000 people; (2) Primary Health Centres (PHC) catering to communities of 5,000 to 20,000 people; and (3) Health Clinics (HCS) accommodating 2,000 to 5,000 persons.

In 1988, Nigeria unveiled its first National Health Policy to address the country's growing health problems by reorganising healthcare delivery and promoting basic healthcare. This approach reinforced the World Health Organization's (WHO) belief that primary

[47] Ibid.

[48] Balogun (n 45) 57.

[49] Olaronke (n 46).

healthcare is the cornerstone of healthcare delivery. The National Primary Health Care Development Agency (NPHCDA) was established to oversee primary healthcare services and achieve universal health coverage.[50]

Although primary health care is aimed at reaching Nigerians at the grassroots and providing accessible health for all, this goal has yet to be attained. This is due to a combination of issues: illiteracy, lack of understanding of primary healthcare among health professionals and decision-making resulting in poor quality services and ill-attitude of health workers, among others.[51]

1.3.2 Secondary Healthcare

Secondary healthcare serves as the intermediary between primary and tertiary healthcare. General hospitals fall within the purview of the state government and provide specialised services such as diagnostic testing and surgery.[52] To reduce the strain on tertiary healthcare institutions, secondary healthcare facilities manage cases that do not require the highly specialised training characteristic of teaching hospitals or national specialist centres. They offer both in-patient and out-patient services.

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[50] National Primary Health Care Development Agency (NPHCDA) Website <https://nphcda.gov.ng> accessed 5 September 2024.

[51] IS Abdulraheem, AR Olapipo and MO Amodu, 'Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities' (2012) 4 (1) Journal of Public Health and Epidemiology 5< https://academicjournals.org/journal/JPHE/article-full-text-pdf/F333DB74249> accessed 3 February 2025. IS Abdulraheem, AR Olapipo and MO Amodu, 'Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities' (2012) 4 (1) Journal of Public Health and Epidemiology 5< https://academicjournals.org/journal/JPHE/article-full-text-pdf/F333DB74249> accessed 3 February 2025.

[52] Abideen, Alade and Hadir Olasunkanmi, 'Secondary Health Care Service Quality and patients' Satisfaction in Ogun State Nigeria,' (2023) 1 Economic and Applied Informatics, 'Dunarea de Jos' University of Galati, Faculty of Economics and Business Administration 89.

Due to high population density, secondary healthcare is designed to support the tertiary system by managing patient care. However, numerous issues within Nigeria's secondary healthcare system require attention, as they significantly affect patient care standards and contribute to medical malpractices. These challenges are cradled from understaffing, medical errors, and malpractice, all of which can negatively impact patient care.

One of the major purposes of secondary healthcare is to manage more complex cases that cannot be handled at the primary care level. However, due to the poor referral system, many patients opt to receive their care directly from secondary or tertiary hospitals rather than through primary healthcare facilities.[53] Consequently, secondary healthcare facilities become overcrowded, admitting patients who could have been treated at a lower level in other hospitals.[54] Furthermore, frequent delays occur in the referral process of tertiary institutions when patients require specialised care that secondary hospitals cannot provide. These delays may lead to fatal outcomes, particularly in emergencies. The lack of transportation infrastructure and ambulance services complicates the referral process, leaving patients in general hospitals ill-equipped to manage their conditions. Due to these systemic inefficiencies, patients may not receive timely or appropriate care, increasing the risk of medical negligence.[55]

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[53] Francis Koce, Gurch Randhawa and Bertha Ochieng, 'Understanding healthcare self-referral in Nigeria from the service users' perspective: a qualitative study of Niger state' (2019) 19 BMC Health Services Research <https://rdcu.be/eaqz7> accessed 3 February 2025.

[54] Francis G Koce, G Randhawa and B Ochieng, 'A qualitative study of healthcare providers' perceptions and experiences of patients bypassing primary healthcare facilities: a focus from Nigeria' (2020) 4 Journal of Global Health Reports <www.joghr.org/article/14138- a-qualitative-study-of-health-care-providers-perceptions-and-experiences-of-patients-bypassing-primary-healthcare-facilities-a-focus- from-nigeria> accessed 12 November 2024.

[55] Koce and Randhawa (n 53); Olaitan Olusegun, 'Emergency Medical Care and the Law in Nigeria: Towards Protection of Patients' Rights' (2023) XIX Journal of Health & Biomedical Law 251.

1.3.3 Tertiary Healthcare

The Federal Government of Nigeria and the Federal Ministry of Health oversee tertiary healthcare, including federal medical centres as well as teaching and specialist hospitals. In addition to formulating general healthcare policy, the federal government is also responsible for providing technical support to the healthcare system.[56]

Furthermore, the implementation of the National Health Policy at the state level is coordinated by the Federal Government, which also holds primary responsibility for developing health management information systems and providing policy advice, planning, and technical support.[57] The Federal Government oversees the management of vaccines, drug regulations, disease surveillance, and training for healthcare professionals. In addition to managing certain medical facilities, the federal government oversees teaching hospitals, mental health services, and orthopaedic hospitals.[58] Although tertiary facilities provide highly specialised medical care and training, they face challenges due to a shortage of funding and resources, leading to inconsistent service delivery.[59]

[56] The World Bank Group Archives, the National Health Policy and Strategy to achieve health for all Nigerians Report (1988) <Ihttps://thedocs.worldbank.org/en/doc/929691562140346971-0240021988/render/WorldBankGroupArchivesFolderD204877.pdf> accessed 1 September 2024.

[57] Balogun (n 45) 6.

[58] Christian Connections for International Health, 'Faith-Based Organisations & Health System Strengthening' (2021) <https://www.ccih.org/wp-content/uploads/2017/09/HSS-FBO-Report-Nigeria.pdf> accessed 7 August 2024.

[59] Ibrahim Abubakar et al., 'The Lancet Nigeria Commission: investing in health and the future of the nation' (2022) 399 Lancet (London, England) 10330, 1155.

Despite this structure, there is a lack of accountability and coordination between the tertiary, secondary and primary healthcare systems in healthcare delivery in Nigeria, impacting health outcomes.[60]

1.4 Systemic Deficiencies of the Nigerian Healthcare System

Within the healthcare ecosystem, certain deficiencies persist in undermining the system despite various reforms the government has attempted to implement. These deficiencies are discussed below.

a. Funding

All financial aspects of the public health sector – labour expenses, consumable costs, operating costs, and capital investment– are the responsibility of federal, state, and local governments respectively.[61] Nigeria stands at the extremes of two spectra- wealth and poverty- rich in resources yet poor in their utilisation. This directly impacts the allocation of the country's budget to health. For instance, the 2024 Federal Government Budget allocated ₦1.38 trillion (5.03%) of the annual budget to the health sector, contrasting with the Abuja Declaration of 2001, which mandates federal and state governments to allocate at least 15% of their budgets to healthcare. Unfortunately, 2012 recorded the highest percentage of the nation's overall budget allocated to the health sector at just 6.23%, significantly below the target.[62] Whilst the health budget is unimpressive, another critical

[60] Koce and Randhawa (n 53).

[61] Christian Connections for International Health, 'Faith-Based Organisations & Health System Strengthening' (2021) <www.ccih.org/wp-content/uploads/2017/09/HSS-FBO-Report-Nigeria.pdf> accessed 1 September 2024

[62] development Research and Project Centre (dRPC) 'Analysis of the Federal Government of Nigeria 2024 Health Budget Proposal', December 2023, Available at <https://drpcngr.org/wp-content/uploads/2023/12/Analysis-of-the-2024-Health-Budget-Proposal-by-the-Federal-Government-of-Nigeria-dRPC.pdf> 1 September 2024.

challenge is the release of even a smaller fragment of the budget due to bureaucracy and limitations in revenue.

These constraints substantially affect the quality of care and service delivery. Additionally, shortages of resources, including outdated equipment and medical supplies, stem from insufficient funding, forcing many patients to shoulder their healthcare costs through out-of-pocket expenses, which can pose a significant barrier to accessing essential healthcare services.[63] Due to the lack of funding, healthcare professionals continue to face the challenge of working with limited available resources, heightening the risks of medical negligence. Medical negligence is more likely in hospitals, clinics, and other healthcare facilities as they are frequently unprepared to manage even basic procedures, let alone complex medical emergencies.

Additionally, primary healthcare services are impacted by local governments' non-functionality and lack of autonomy. These governments seldom receive their budgetary allotments from the Federal and state governments, which has almost rendered them ineffective.[64]

Further, taxes and out-of-pocket spending with minimal insurance primarily finance the

[63] Abubakar (n 59).

[64] Ejemai Amaize Eboreime et al, 'Strengthening decentralized primary healthcare planning in Nigeria using a quality improvement model: how contexts and actors affect implementation' (2018) 33(6) Health Policy and Planning 715; Michael Sunday et al, 'Local Government Finance in Nigeria: Challenges and Prognosis for Action in a Democratic Era' (2014) 2(1) Journal of Good Governance and Sustainable Development in Africa 84; Maurice Ayodele Coker & John Anyabe Adams, 'Challenges of Managing Local Government Finance in Nigeria' (2012) 2 (3) Research on Humanities and Social Science <https://core.ac.uk/download/pdf/234672926.pdf.> accessed 22 July 2024.

Nigerian healthcare system. Balogun noted that 'in many developing countries, the private sector's share of total health spending is three or four times the amount of public health expenditure' and that 'private establishments now account for over 60% of healthcare services in the country.'[65] This is evidenced by Nigeria's health spending, as asserted by the Healthcare Federation of Nigeria, where private healthcare dominates the health ecosystem, managing over 70% of healthcare delivery.[66] Furthermore, World Bank data indicates that private health expenditure in Nigeria constituted 71.3% of total expenditure in 2019, exceeding public spending.[67]

b. Inadequate infrastructure

The health system lacks state-of-the-art medical equipment and facilities, and the effect thereof is grave, particularly during hot weather conditions without air conditioning. Balogun noted, 'the Nigerian healthcare system is grossly underdeveloped and does not conform to many global best practices.'[68] The majority of health infrastructure is concentrated in urban areas, in contrast to rural locations. Umeh highlighted that 'health resources are skewed towards secondary and tertiary healthcare' and that 'the availability of a higher cadre of health workforce (doctors, nurses) is also biased in favour of secondary and tertiary facilities, which are typically situated in urban regions.'[69] Access to healthcare for Nigerians is exceedingly unequal, with urban areas receiving markedly better treatment than rural ones. Residents of numerous rural towns must travel long distances to reach the

[65] Balogun (n 45) 96.
[66] Grace Edema, 'Private Sector Handles 70% Healthcare Delivery in Nigeria,' (2024) <https://punchng.com/private-sector-handles- 70-healthcare-delivery-in-nigeria-hfn/>accessed 2 September 2024.
[67] Ibid.
[68] Balogun (n 45) 57.
[69] Chukwuemeka Umeh, 'Challenges towards achieving universal health coverage in Ghana, Kenya, Nigeria and Tanzania,' (2016) 33 (4) International Journal of Health Planning Management 779.

nearest healthcare institution, which is often understaffed and underfunded. This disparity in access leads to delays in patients seeking medical help until their condition significantly worsens. In emergencies, waiting too long to seek medical attention can be fatal. Medical negligence frequently arises from the healthcare system's inability to provide timely and appropriate care, especially in rural areas. Additionally, facilities that have infrastructure are often ill-maintained, which sometimes leads to costly failures during emergencies and healthcare delivery.[70]

Furthermore, electricity is a luxury in Nigeria and is unaffordable for many healthcare facilities. Numerous healthcare practitioners must adapt to care delivery under inappropriate conditions, such as performing surgeries without power and sometimes resorting to the use of alternate sources of illumination such, as candles.[71] Other shortcomings include a lack of access to clean water, medical supplies, and functioning medical equipment. Patients are occasionally required to provide their medical supplies, such as gloves, syringes, and even blood donors, highlighting the system's inability to deliver basic healthcare. Although both the private and public sectors have attempted to synergise resources through public-private partnerships (PPPs), this has not significantly impacted the populace, as the services offered by the PPPs are costly and beyond the reach of the economically disadvantaged.[72]

[70] Esther Oladejo, Obinna Umeh and Charles Egolum, 'The Challenges of Healthcare Facilities Maintenance in Tertiary Hospitals in South East Nigeria' (2015) 3 (2) International Journal of Civil Engineering Construction and Estate Management 1.

[71] Oluwatosin Adeshokan, 'Surgery by candlelight: hospitals in Nigeria suffer losing power- and staff' (2020) <www.theguardian.com/global-development/2020/jan/07/surgery-by-torchlight-hospitals-in-nigeria-suffer-losing-power-and-staff> accessed 2 September 2024.

[72] Balogun (n 45) 57.

c. Health Workers Shortage and Attrition

Nigeria is facing a significant shortage of healthcare providers, exacerbated by brain drain- the departure of highly qualified individuals seeking better opportunities in other countries. This exodus affects the availability of trained healthcare professionals in Nigeria and diminishes the overall quality of service. For instance, as of December 2023, over 12,000 Nigerian-trained medical doctors are practising in the UK alone,[73] not to mention other healthcare professionals.

The attrition rate has made healthcare professionals overworked, making it challenging to meet the needs of an ever-increasing number of patients. This shortfall directly impacts the quality of care, heightening the risk of medical negligence.

Aderinto, Kokori and Olatunji noted that the doctor-patient ratio in Nigeria is a concerning 1:9083, which is significantly higher than the recommended 1:600.[74] This disparity between patients and healthcare professionals is likely to result in rushed consultations and misdiagnoses due to burnout and exhaustion. For example, a house officer at Lagos State Teaching Hospital, Dr Umoh Michael, tragically passed away on 17 September 2023 after completing a 72-hour shift in the neurosurgery unit.[75] Such extensive hours increase the risk of medical errors that jeopardise patient safety.

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[73] Punch News, '1,197 Nigerian-trained doctors move to UK since May,' (2023) <https://punchng.com/1197-nigerian-trained-doctors-move-to-uk-since-> accessed 2 September 2024.

[74] Aderinto, Kokori and Olatunji, 'A call for reform in Nigerian medical doctors' work hours, (2024) 402 (10428) The Lancet 727.

[75] Eniola Daniel, 'Doctor dies after allegedly working 72 hours in LUTH' (2023), The Guardian <https://guardian.ng/news/doctor-dies-after-allegedly-working-72-hours-in-luth/> accessed September 2024.

d. Cost of Governance and Corruption

Weak governance is another reason for the health system's inability to deliver optimum service. Although a three-tiered health system exist, poor management and corruption continue to undermine these structures due to inadequate planning, a lack of political integrity, corrupt practices, misaligned policy priorities, and extreme political and economic pressures.[76]

While corruption penetrates all facets of Nigerian society, the health sector has not been exempted. Corruption has been a hallmark of nearly every regime in Nigeria. Although President Muhammadu Buhari's administration focused on combating corruption, the country only fell deeper into corrupt practices, becoming one of the most corrupt nations in the world.[77] Further, the real problem of exterminating corruption is that most politically exposed persons often enjoy a quantum of protection from the government of the day.[78] The medical sector is not immune to this tradition of corruption embraced by Nigerian leaders and elites. Nigerian elites spend over $1.5 billion annually on medical tourism. Many government officials frequently seek medical treatment abroad, funded by governmental resources, leaving citizens to struggle with the deteriorating health system.[79] For instance, President Muhammadu Buhari, among other officials, would typically travel abroad to treat ear infections. The corruption of circumventing processes and procedures

[76] Balogun (n 45) 119.

[77] Transparency International, 'Corruption Perception Index' (2024) <https://transparencia.org.es/wp-content/uploads/Report_CPI2023_English.pdf> accessed September 2024.

[78] Human Rights Watch, 'Violence, "Godfathers" and Corruption in Nigeria: Summary,' (October 2007) <www.hrw.org/reports/2007/nigeria1007/1.htm> accessed 1 September 2024.

[79] Balogun (n 45) 126.

in Nigeria led a Senator and his wife to be found guilty of conspiracy for trafficking a 21-year-old street vendor from Nigeria to the UK to harvest his kidney for their daughter in 2023.[80] While this is chiefly a trafficking case, it underscores the pervasive nature of medical tourism pursued by many Nigerian elites.

Furthermore, corruption exists within the healthcare system, including the misappropriation of public funds, diversion of resources, and the imposition of unofficial fees for services that should be provided free or at a reduced cost.[81] The inadequate resources necessary for effective operation and the mismanagement of healthcare funding adversely affect service delivery, significantly heightening the chances of errors and negligence when medical professionals are forced to work in an environment lacking basic and essential supplies and medications.

1.5 The Nigerian Healthcare System: A Threat to Patient Safety and a Fuel for Medical Negligence.

The safety of patients is an important issue that has gained traction in discussions of medical negligence and has enriched the global literature on how healthcare systems can prevent adverse events. For instance, Tingle's examination of safety policy development in the NHS in England noted that 'in 2005, the National Audit Office looked into patient safety and found that improvements in safety culture had occurred due to the development

[80] Christien Ro, 'Nigeria Has a New President, but a Familiar Debate About Medical Tourism' (2023) <www.forbes.com/sites/christinero/2023/05/29/nigeria-has-a-new-president-but-a-familiar-debate-about-medical-tourism/> accessed 2 September 2024.

[81] Monica Ewomazino Akokuwebe & Erhabor Sunday Idemudia, 'Fraud within the Nigerian health system, a double threat for resilience of a health system and the response to the COVID-9 pandemic: a review' (2023) 45 Pan African Medical Journal 116 < https://pmc.ncbi.nlm.nih.gov/articles/PMC10516760/> accessed 24 July 2025; Obinna Onwujekwe et al. ' Corruption in Anglophone West Africa health systems: a systematic review of its different variants and the factors that sustain them' (2019) 34(7) Health Policy and Planning 529.

of risk management', suggesting that patient safety should be prioritized.[82] This issue is of particular concern in the sub-Saharan context, where patients' needs have been severely neglected because of a lack of resources, understaffing, and inadequate healthcare facilities that compromise quality treatment. Nevertheless, the imperative to prevent unjustifiable patient deaths has spurred the development of safety cultures aimed at revealing existing barriers to adequate healthcare across various jurisdictions. While researchers have concentrated on understanding the impact of patient safety within healthcare settings, there remains a dearth of research on the preventability of patient safety incidents in a global context, which limits our knowledge and understanding of key factors that reduce adverse events.

However, in 2002, the World Health Organization's Health Assembly urged its members to prioritise patient safety and establish and strengthen science-based systems necessary for improving patient care and the quality of healthcare.[83] Furthermore, since recognising the need to ensure patients' safety within healthcare settings, it has been observed that medical negligence arises from systemic issues rather than individual failings. Additionally, international agreements have been established between the World Alliance for Patient Safety and the World Health Organization, advocating for urgent understanding, action, and improvements in the safety culture within sub-Saharan African countries.[84] The regional director of the World Health Organization for Africa has also

[82] John Tingle, Clayton Ó Néill and Morgan Shimwell, Global patient safety: law, policy and practice (1st edn Routledge, 2018).

[83] Nwosu et. al, 'Patient Safety Awareness among 309 surgeons in Enugu, Nigeria: a cross-sectional survey' (2019) 13 Patient Saf Surg 33.

[84] Robert Kaba Alhassan et. al, 'Effect of Community Engagement Interventions on Patient Safety and Risk Reduction Efforts in Primary Health Facilities: Evidence from Ghana' (2015) 10 (11)PLoS One <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0142389 > accessed 10 December 2024.

noted that the majority of countries in the region lack a national policy on safe healthcare practices[85]. While efforts have focused on developing local organisations to improve patient care and meet international standards, the culture of inadequate treatment and facilities necessary for proper care of the population continues to persist.

There is a pressing need to raise awareness in hospitals across Nigeria by providing training assistance to medical professionals on international standards and safety checklists designed to enhance patient safety. For example, a 2009 study of surgeons reveals that 65.3% of surgeons were unaware of the surgical safety checklist introduced by the World Health Organization in 2009.[86] Likewise, in India, 'only 57of surgeons have heard of the World Health Organization (WHO) surgical safety checklist, and merely 32% incorporate it into their surgical practice.'[87] It is also essential to transition from a practice of autonomy to one that involves physicians, patients, and their families in collaborative efforts to prevent medical malpractice. This safety culture, particularly evident in countries like Nigeria- known for systematic defects and poor patient safety outcomes- must be nurtured to diminish the risk of adverse events. However, this safety culture can be achieved through the enhancement of healthcare infrastructure and reforms in medical education, which should make more physicians conscious of the importance of implementing best practices to prevent medical negligence within the healthcare system.

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[85] Mohammed Fahmi et al, 'Guide for Developing National Patient Safety Policy and Strategic Plan' (December 2014) World Health Organisation, Africa <www.afro.who.int/sites/default/files/2017-06/guide-for-developing-national-patient-safety-policy-and-strategic-plan_final.pdf> accessed 3 December 2024; Musa Sani Kaware et al, 'Patient Safety Culture and its Associated Factors: A Situational Analysis among Nurses in Katsina Public Hospitals, Northwest Nigeria,' (2022) 19 (6) International Journal of Environmental Research and Public Health 1 <https://pmc.ncbi.nlm.nih.gov/articles/PMC8951849/pdf/ijerph-19-03305.pdf> accessed 12 January 2025.

[86] Ibid (n 83); Geraldo de Rocha Motta Filho and others, 'The WHO Safety Checklist: Knowledge and use by Brazilian orthopaedists' (2013) 48 (6) Revista Brasileira De Ortopedia 554.

[87] Malhotra MK and others, 'Surgical Safety Checklist Popularity among the surgeons? A survey' (2017) 16 (4) Bangladesh Journal of Medical Science 521.

Anecdotal evidence suggests that there has been little to no improvement in patient safety in developing countries like Nigeria. The lack of sufficient data on health quality has complicated patient safety.[88] This is partly due to the blame culture (see Chapter 2) within the Nigerian healthcare system and the persistent underreporting of medical negligence cases. Indeed, the state of medical care in Nigeria reflects a narrative of patients who have grown accustomed to the status quo, characterised by inadequately equipped hospital wards, unsanitary restrooms, and limited medication for treatment. However, safety systems have been established to enable healthcare workers to report errors without fear of punishment or stigma, thereby enhancing safety standards. For instance, since the inception of the WHO patient safety programme in 2004, over 140 countries globally have committed to intensifying efforts to address challenges related to unsafe and poor-quality healthcare through established science-based systems.[89] While countries have adopted WHO programmes, evidence suggests that frontline healthcare professionals believe current approaches are limited, misguided, or misplaced.[90] Although Nigeria continues to strive for safer healthcare and regulatory reforms, these efforts have not entirely prevented harm to patients. Sharing information between health organisations and between patients and their families is of utmost importance as this will ensure incident reporting and facilitate a better understanding of the causes of adverse outcomes. Incident reporting will generate data and inform research regarding the experiences of patients who have suffered

[88] Michael A. Chiangi, 'Principles of Medical Negligence: An Overview of the Legal Standard of Care for Medical Practitioners in Civil Cases" (2019) 4 (4) Miyetti Quarterly Law Review 53.

[89] Alhassan (n 81); World Health Organisation, 'A brief synopsis on patient safety' (2010) <https://seguridaddelpaciente.sanidad.gob.es/informacion/publicaciones/otrasPublicaciones/docs/E93833.pdf> accessed 3 February 2025.

[90] Joanna Wailling. 'How healthcare professionals in acute care environments describe patient safety: A case study' (Master's thesis, Victoria University of Wellington 2016).

from medical malpractice in Nigeria. It may also aid in addressing initial harm by providing compensation information.

Furthermore, it must be acknowledged that safety within the healthcare environment is the responsibility of all stakeholders and necessitates the design of a process that can both prevent and rectify harm. Nevertheless, it should be emphasised that harm can be attributed to a deficient patient safety culture rather than solely a focus on systems and processes.[91] Research indicates that a safety culture should be developed alongside traditional processes and reporting systems within healthcare organisations.[92] While it is contended that it is necessary to address and modify the culture of systems and structures, one must also recognise that harm stays with patients indefinitely. They are impacted by its emotional repercussions, which subsequently lead to mental health instability and issues. Thus, there is a need for a new direction and the establishment of innovative systems and structures that will repair and prevent harm experienced by patients.

1.6 Future Indications of Medical Practice in Nigeria

The United Nations' Sustainable Development Goal 3 aims to achieve Universal Health Coverage (UHC) for all people by 2030.[93] However, many countries, including Nigeria, are far from reaching this objective.

[91] Ibid.

[92] Livia Nell Hardy, 'How do district health boards respond to and use the serious sentinel event report?'(Master's thesis, university of Otago 2013); Lucian Leape, 'Errors in Medicine' (2009) 404 Clinical Chimica Acta 2.

[93] World Health Organisation, 'Universal health coverage' (2023) <www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)> accessed 3 September 2024.

In recent years, efforts have been intensified to address the shortcomings of the Nigerian healthcare system. Initiatives such as the Primary Treatment Revitalisation Programme and the National Health Insurance Scheme (NHIS), which was established under the National Health Insurance Scheme Act of 2005 and later repealed by the Nigerian Health Insurance Authority Act 2022, are intended to alleviate the financial burden on patients and enhance access to treatment. However, these programmes have struggled to gain traction due to insufficient funding, a lack of accountability, and weak governance.

Furthermore, despite these UHC-focused initiatives, fewer than 5% of the population has health insurance.[94] For instance, in Nigeria, states have the autonomy to decide whether to provide health insurance for their workers. As noted by Umeh, only three of the 36 states- Enugu, Cross River, and Bauchi- have enrolled their personnel under the NHIS, one reason being the reluctance of both states and workers to engage in the scheme.[95] Similarly, under the NHIS Act 2005, there is no obligation for private sector employees working in the formal sector to enrol in the NHIS, let alone for those employed in the informal sector. However, the existing legislation, the National Health Insurance Authority Act 2022, aims for universal health coverage and has significantly improved the regulatory framework governing health insurance coverage to encompass all Nigerian citizens and legal residents. Notwithstanding, the legislation remains in its potential, as most Nigerians and residents have yet to benefit from universal health coverage.

[94] Balogun (n 45) 120.

[95] Umeh (n 69) 800.

It is imperative to restructure Nigeria's healthcare system to enhance patient outcomes and reduce the prevalence of medical errors. Increasing funding for hospitals, improving the training and retention of healthcare workers, and addressing systemic corruption and mismanagement should be the main areas of improvement. To ensure that patients receive the care they require at the appropriate level, a more effective referral system must be implemented, supported by improved infrastructure and transportation networks. The foundation of the Nigerian healthcare system should ultimately be the collaborative efforts of the three-tiered healthcare structure; however, this will necessitate substantial investment in financial and human resources, including expertise, political will, and strategic management by primary stakeholders. Reducing the incidence of medical neglect and providing Nigerians with the high-quality treatment they deserve requires tackling these systemic issues. It is essential to note that while these recommendations are necessary for achieving a better healthcare system in Nigeria, they are not the primary focus of this thesis.

Nigerian healthcare providers, in partnership with the government, can resolve the country's healthcare issues. As in most developed nations, healthcare delivery is typically provided by doctors and other medical professionals; hence, they should take responsibility for poor health outcomes just as much as they do for good medical treatment.[96]

[96] Scott-Emuakpor (n 16) 62.

Furthermore, Nigeria's legal and regulatory frameworks regarding medical practice and negligence require substantial reform to create a safer and more accountable healthcare environment. Patients who have experienced medical negligence face difficulties in receiving compensation or redress due to the shortcomings of the current tort system, which is ill-equipped to manage their cases effectively or justly. While issues such as underfunding, shortages of healthcare personnel, inadequate governance, and legislative deficiencies need to be addressed, Nigeria must shift towards a more patient-centred, efficient, and equitable healthcare system. However, to achieve this ideal health system, prioritising increased investment, retaining healthcare professionals, implementing comprehensive legal reforms, and integrating alternative dispute resolution mechanisms, such as restorative justice and no-fault compensation systems, is essential.

1.7 Conclusion

Nigeria’s healthcare system has historically evolved, leaving a legacy of structural flaws that compromise the standard of care. The colonial emphasis on providing healthcare for a small group of privileged individuals has resulted in Nigeria, years after independence, still yet to achieve universal healthcare. The system requires urgent intervention; however, this should not absolve health practitioners of their responsibilities towards their patients.

This chapter has discussed some of the health failures underpinning medical negligence in Nigeria, which are shaped by a combination of policy, polity, and deficient management. These combined factors have further weakened the health system and affected the quality of care that patients receive, nearly making medical errors and negligence unavoidable.

Furthermore, this chapter examines the three-tiered medical structure of the Nigerian health system, which has led to its inefficiency due to insufficient collaboration between the federal, state, and local governments in fostering positive health outcomes. The lack of enforcement concerning the applicability of the health insurance scheme to all individuals, coupled with the requirement for patients to take primary responsibility for supplying medical necessities, further highlights the flaws within the health system.

The state of the Nigerian healthcare system demands urgent attention from the government, medical practitioners, patients, communities, and all stakeholders at different levels. Due to the shortcomings of the Nigerian healthcare system- poor infrastructure, underfunding, staff shortages, and corruption- medical neglect is widespread. In addition to compromising the quality of care, these systemic issues make it increasingly difficult for negligent parties to seek legal recourse through the tort system. In the forthcoming chapters, this thesis will explore various approaches to tackling medical malpractice, including restorative justice and no-fault schemes. These methods offer a more accessible and equitable framework for resolving medical disputes in Nigeria by emphasising healing, accountability, and systemic improvement. Although medical negligence cannot be completely eradicated, it can be significantly minimised if the Ubuntu, restorative, and no-fault models proposed later in this thesis are implemented.

CHAPTER TWO

EXAMINING MEDICAL NEGLIGENCE IN NIGERIA: THE INADEQUACY OF THE TORT SYSTEM AND STATUTORY PROVISIONS FOR PATIENTS TO SEEK REDRESS

2.1 Introduction

This chapter builds on the discussion in Chapter 1 regarding the general limitations and failings of the Nigerian health system. It focuses on the weaknesses of the Nigerian tort system and statutory provisions, the two avenues through which claimants can pursue their claims for medical negligence in Nigeria. Although there are substantive and procedural laws that provide for the use of alternative models, such as arbitration, mediation,[97] and negotiation, as outlined by the National Health Insurance Authority Act 2022[98], and the Arbitration and Mediation Act 2023 (AMA),[99] this system design remains problematic because it ignores patient safety and medical practitioners' responsibility, placing the burden of proof on patients.

Furthermore, this chapter explores the following key questions: First, is the Nigerian tort system effective in compensating patients who have suffered from medical negligence? Second, does it hold medical practitioners accountable for incidents of medical negligence? Third, do the tort system and statutes adequately address the needs of patients?

[97] The repealed Arbitration and Conciliation Act 2004 made provision for conciliation.

[98] See s 46 (1) – (4). This Act is an upshot of the National Health Insurance Scheme Act 2005.

[99] This is the newest legislation repealing the Arbitration and Conciliation Act 2004.

To answer these questions, an examination of the tort system in Nigeria will be conducted. The tort system provides a framework for claimants to initiate lawsuits. Additionally, the literature on the tort system will be critically reviewed to assess whether the legal framework for obtaining compensation for medical negligence can be improved for patients in Nigeria.

Consequently, this chapter will critically assess the Nigerian tort system and its shortcomings. It will also explore the statutory rights of patients under the law. Finally, it will consider whether it may be necessary to introduce alternative systems of redress to promote patient safety and healing following instances of medical negligence, as well as the responsibility of medical practitioners in achieving this objective.

2.2 The Current System – The Fault-Based (Tort) System in Nigeria

One of the foundational sources of the Nigerian legal system is common law, as Nigeria was previously a colony of Great Britain and later became a member of the Commonwealth.[100] In contrast, research shows that the United Kingdom has reformed its healthcare system- albeit imperfectly- to offer compensation to patients suffering from medical negligence as an alternative to the traditional litigation process.[101] Meanwhile, in Nigeria, the legal framework for medical negligence is predominantly based on common law, which has not experienced a necessary overhaul since independence in 1960, as

[100] Labbo Abdullahi, 'An African construction of colonial medicine: the Sokoto people's perception and response to the British healthcare programmes,' (2019) 3(5) Sociology International Journal 362.

[101] Paul Fenn, Alastair Gray and Neil Rickman, 'The Economics of Clinical Negligence Reform in England' (2004) 114(496) The Economic journal (London) F272.

discussed in Chapter 1. Consequently, this section seeks to provide an exposition of the state of the Nigerian tort system and how patients continue to face challenges in accessing justice when confronted with medical negligence.

The Nigerian healthcare system continues to experience high levels of medical negligence;[102] many patients affected by such negligence at the hands of practitioners are discouraged from pursuing legal action to seek compensation or damages. There is an army of reasons for this, such as poor patient awareness, litigation costs, difficulty in procuring expert witnesses and religious and cultural complexities, among others.[103] Further, the reluctance arises because those who file claims through litigation (the fault-based system), which is fundamental to tort law (common law), often face negative consequences from the process, including delays in attaining justice and difficulties in fulfilling the requirements to achieve it.

While there has been a dearth of literature on patient and medical practitioners' satisfaction with the current regime, scholars[104] have made efforts to analyse case law and examine Nigerian tort law, suggesting that patients and medical practitioners are dissatisfied with the system. As noted by Bayero et al., despite the provisions of the constitution, the existence of several other laws, and a regulatory body requiring medical

[102] D O Okanyi and G O Guruje. 'Social-Cultural, Economic, Religious and Legal Impediments to the Implementation of the Law Relating to Medical Negligence in Nigeria' (2019) 1(1) IRLJ 149.

[103] Kamorudeen Adegboyega, 'Medical Negligence in Nigeria and the Obstacles to Litigation' (2023) 1 MAAUN International Multidisciplinary Journal of Research and Innovations 1.

[104] Adebiyi Anthony Adepoju and Cheluchi Onyemelukwe Onubia, 'An Analysis of Compensation in Medical Negligence in Nigeria' (2020) (2) European Journal of Law and Political Sciences 27; Adekunle Ope, 'Medical Negligence in Nigeria' (1995) 14 Law Journal Library, Medicine and Law 453.

personnel to deliver healthcare services with the requisite skill, safety, and ethical standards, incidents of medical negligence, including wrong diagnoses and a lackadaisical attitude towards the expected duty of care, have consistently increased in Nigeria over the years.[105] The sub-section below explores how fault is established in medical negligence claims.

2.3 Pursuing a Claim of Medical Negligence in Nigeria

To establish a medical negligence claim, proving the core elements of negligence is essential, including demonstrating the fault of the medical practitioner alleged to have caused harm to the patient. The chronological approach to establishing fault before the court is discussed below; however, we must first determine what negligence entails.

2.3.1 What is Professional Negligence?

Negligence is defined as an act or omission that falls below the standard expected of a reasonable person.[106] It is also characterised by a failure to perform an action that a reasonable person, guided by considerations that typically govern human conduct, would do or by undertaking an action that a prudent, reasonable person would not do.[107] Implicitly, professional negligence occurs when a breach of the legal or fiduciary duty imposed on a professional results in harm to the recipient of those services.

[105] Bayero Jimoh and others, 'Physicians and wrong diagnosis of patients: An assessment of Legal duties and liabilities in Nigeria' (2016) 7 Nnamdi Azikiwe University Journal of International Law and Jurisprudence 90.

[106] Otti v. Excel- C Medical Centre Ltd & Anor [2019] LPELR- 47699 (CA).

[107] Blyth v. Birmingham Waterworks [1856] 11 Ex, 781 784.

Medically, professional negligence is the breach of the legal (fiduciary) duty of care owed by medical professionals while performing their responsibilities. In a broad sense, it refers to a medical practitioner's failure to provide optimal care reasonably expected while fulfilling their duties to a patient. It can also be characterised as the failure of a medical practitioner to act in a manner that deviates from accepted medical practice.[108] Medical negligence is a failure to act in accordance with the protocols and regulations governing the practice of medicine in any given jurisdiction. Examples of such acts are misdiagnosis, inappropriate treatments, improper transfusion, and wrongful administration of medication, among others. According to Lord Denning, in the case of *Hatcher v. Black,*[109] medical negligence can be likened to a dagger in the back of a medical practitioner, potentially affecting their future practice.

Although the terms 'medical negligence' and 'medical errors' are often used interchangeably, the two have slight underlying differences. A medical error can be defined as a mistake that does not fall below the standard of reasonable care required of medical practitioners (generally considered not foreseeable). In contrast, the tort of negligence involves failing to act as a competent and reasonable medical practitioner is expected to act (usually involving a case of damage and causation).[110] However,

[108] O L Udemezue and P U Ogbonna, 'Medical Negligence as a Limitation to the Right to Health and Healthcare: The Nigerian Perspective' (2018) 14 UNIZIK Law Journal.

[109] [1954] Times 2 July.

[110] Ivan Miziara and Carmen Miziara, 'Medical errors, medical negligence and defensive medicine: A narrative review' (2022) 77 Clinics (Sao Paulo, Brazil) 100053 < https://pmc.ncbi.nlm.nih.gov/articles/PMC9160317/pdf/main.pdf> 10 February 2025; Femi Oyebode, 'Clinical Errors and Medical Negligence' (2013) 22 (4), Medical Principles and Practice 3; Munley Law, 'What is the difference between medical errors and medical negligence in Allentown' <https://munley.com/allentown/medical-malpractice-lawyer/what-is-the-difference-between-a-medical-error-and-negligence/#:~:text=Medical%20errors%20are%20generally%20not,have%20foreseen%20and%20acted%20differently.> accessed 10 February 2025.

negligence *per se* typically refers only to a breach of duty, where negligence is established when the defendant contravenes statutes aimed at protecting a specific class[111] Nonetheless, this paper does not focus on the distinction between medical errors and medical negligence. For the purposes of this thesis, the terms may be used interchangeably to mean the same unless otherwise stated.

The common law test for establishing negligence, articulated by the House of Lords in *Donoghue v. Stevenson*[112] states that there must be (i) a duty of care owed, (ii) a breach of that duty of care, and (iii) harm resulting from the breach of that duty of care. This framework has been accepted in Nigeria and emphasised in numerous cases.[113] Therefore, in the case of *Ojo v. Gharoro & Ors*[114] the Supreme Court applied this standard and held that the essential elements required to establish a negligence claim are to prove that:

(i) the defendant owes a duty of care

(ii) there is a breach of that duty, and

(iii) it resulted in damage.

However, it should be noted that the laws of negligence in Nigeria and England have diverged with developing more refined tests in England.[115]

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[111] Aaron D Twerski, 'Negligence Per se and Res Ipsa Loquitur: Kissing Cousins' (2009) 44 Wake Forest Law Review 997.

[112] [1932] AC 562.

[113] Nigerian Bottling Co. Ltd v. Ngonadi [1985] 5 SC 317; Abusomwan vs. Mercantile Bank [1987] 2 NWLR 9pt. 60) 196; Enyika v. Shell BP Petroleum Development Co. [1997] 10 NWLR (Pt. 526) 638; Ojo v. Gharoro [2006] LPELR – 2383;; R v. Akerele [1941] 6 WACA 211; Edward Okwejiminor v. G. Gbakeji and Anor [2008] 5 NWLR 9Pt. 1079) 172; Kabo Air Ltd v. Mohammed [2015] 5 NWLR (Pt. 1451) 38 CA.

[114] [2006] LPELR-2382 (SC). See also Otti v. Excel -C Medical Centre Ltd & Anor [2019] LPELR-47699 (CA).

[115] See the case of Alcock v. Chief Constable of South Police [1992] 1 AC 310; UK SC 4; Montgomery v. Lanarkshire Health Board [2015] UKSC 11; A v East Kent Hospitals NHS Trust [2015] EWHC 1038; Darnley v. Croydon Health Services NHS Trust [2018] UKSC 50; Robinson v. Chief Constable Yorkshire Police [2018].

2.3.2 What is the medical duty of care?

In the case of *Samson Ebiagbonya v. Dumez (Nig) Ltd & Anor*[116] the Nigerian Supreme Court held that once a medical practitioner is in contact with a patient, a duty of care arises as he discharges his responsibilities. It does not matter at what stage the contact occurs; it could be at the commencement of treatment when he is merely taking the patient's history. From this point, a failure on the part of the medical practitioner to meet the standard of care expected of ordinary members of his profession will constitute a breach of the duty of care. The law will hold the medical practitioner liable for any injury resulting from a lack of the degree of knowledge or skill ordinarily possessed by other members of the professional community in good standing or for a failure to exercise reasonable care and diligence in the practice of his profession, as well as for his failure to exercise his best judgment in the treatment of his patient. Other authors, such as Anthony and Onuobia,[117] have defined the duties of the doctor as (i) diagnosis, (ii) medical advice, and (iii) treatment.

Consequently, a crucial element in establishing medical negligence in Nigeria is demonstrating that a legally recognised relationship exists between the medical practitioner in question and the patient. At first glance, this may seem less challenging, but the fact that a medical practitioner has a fiduciary duty to patients does not guarantee their ability to fulfil this duty adequately, particularly within complex healthcare systems like Nigeria's. In Nigeria, there is a shortage of medical practitioners to meet patient needs[118] especially

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[116] [1986] 3 NWLR Pt. 31, 753 SC.

[117] Anthony and Onuobia (n 101).

[118] Nike Adebowale-Tambe, 'Brain Drain: Nigeria needs 363,000 doctor but has only 24,000' Premium Times (2022)

in public facilities. While this is a systemic issue, the realities of overcrowded hospitals and a shortage of medical personnel continue to persist, alongside challenges related to inadequate numbers of hospitals and substandard medical equipment, which complicate the establishment of the doctor-patient relationship necessary to prove negligence. Nevertheless, the mere fact that an individual presents themselves as possessing special skills and knowledge upon which they can be consulted is sufficient to establish this relationship, which potentially extends to the doctor's undertaking to provide treatment, as stipulated under common law.[119]

2.3.3 What is the breach of medical duty?

Every medical practitioner owes a duty of care to their patients.[120] What this duty entails in each context and when it is breached is a separate question. To establish a breach of medical duty, the patient, usually with the assistance of a legal practitioner, must demonstrate that the medical practitioner failed to meet an appropriate and reasonable standard of care.

This standard will vary according to the situation. In the case of *Olowu v. the Nigerian Navy*,[121] the court observed that failing to attend to a patient in need of medical attention also constitutes medical negligence. Consequently, a breach of duty is not solely the shortfall of a standard in the care provided but also the refusal to offer care where a duty

<www.premiumtimesng.com/news/headlines/560772-brain-drain-nigeria-needs-363000-doctors-but-has-only-24000.html> accessed 15 February 2023.

[119] Festus Oghenemaro Emiri, Medical law and ethics in Nigeria (Malthouse Press 2012).

[120] MS Pandit and Shobba Pandit. 'Medical negligence: Coverage of the profession, duties, ethics, case law, and enlightened defense - A legal perspective' (2009) 25(3) Indian Journal of Urology 372.

[121] [2011] 18 NWLR Pt. 1279, 695 SC.

is owed. This standard is typically measured against the expected standard of comparable professional practice.[122] The Nigerian courts have also upheld this position. For instance, in the Nigerian case of *Otti v. Excel-C Medical Centre Ltd & Anor*[123] the Appellant sued the respondents for failing to comply with his instructions on the form of medication he preferred. The Appellant had informed the respondents that he did not want to be admitted overnight, nor did he want to undergo any form of surgical procedure after receiving a prescription and supply of pain-relieving tablets for his haemorrhoids. The court, relying on the decision in *Ojo v. Gharoro,*[121][124] held that it is fundamental law that to find a medical professional liable for negligence, the circumstances must be such that what he did is something professional colleagues would agree is a mistake that should not have occurred. In other words, the action would not fall below the standard expected of a reasonably skilled medical professional.[122]

The question that arises, then, is what the court's decision will be in cases where there is a conflicting opinion among a doctor's medical colleagues regarding the treatment or procedure that should have been adopted. This issue was examined in two cases that established the Bolam test[125] and Bolitho principle[126] in the United Kingdom. Notably, the English case of *John Bolam v. Friern Hospital Trust*[127] set the standard for professional

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[122] Daniele Bryden and Ian Storey, 'Duty of care and medical negligence' (2011) 11(4) Continuing education in anaesthesia, critical care & pain 124.

[123] [2019] LPELR-47699 (CA).

[124] Ojo (n 111).

[125] [1957] 1 WLR 582.

[126] [1996] 4 All ER 771.

[127] Bolam (n 123); Hunter v. Hanley [1955] SC 200.

care. In this case, the plaintiff suffered fractures due to the administration of electro-convulsive therapy without anaesthetic. At the time, there were two schools of thought on the use of anaesthetic prior to such treatment; one perspective suggested that relaxant drugs should be used beforehand, whereas the other argued that administering relaxant drugs would increase the risk of fractures. The evidence presented to the court raised questions about whether the plaintiff should have been restrained and adequately informed of the associated risks of the procedure. In light of these conflicting schools of thought, McNair J stated that:

> Where you get a situation which involves the use of some special skill or competence, then the test whether there has been negligence or not is not the test of the man on the Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that skill. A man need not possess the highest expert skill at the risk of being found negligent. It is well-established law that it is sufficient if he exercises the ordinary skill of an ordinary competent man exercising that particular art… A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art... Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice merely because there is a body that takes a contrary view… That does not mean that a medical man can obstinately and pig-headedly carry on with some old technique if it has been proved to the contrary to what is substantially the whole of informed medical opinion. Otherwise, you might get men today saying, "I don't believe in antiseptics I am going to continue to do my surgery the way that it was done in the Eighteenth Century.[128]

[128] Bolam (n 123) 586-587.

The test for determining professional standards is such that an ordinarily skilled individual, claiming to possess that particular skill and care, will exercise the same level of skill as that exhibited by the most experienced medical doctor unless that individual is a consultant. Likewise, this position was affirmed by the Nigerian Court in the case of *Abi v. CBN & Ors*[129] In this instance, the court, when examining when a doctor will be held liable for medical negligence, ruled that:

> The Courts have long recognized that there is no negligence if a doctor exercises the ordinary skill of an ordinary competent man professing to have that special skill. The locus classicus of the test for the standard of care required of a doctor or any other person professing some skill is the direction to the jury given by McNair J in Bolam v. Friern Hospital Management Committee… A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a

[129] [2011] LPELR-4192 CA.

> responsible body of medical men skilled in that particular art. I do not think there is much difference in the sense. It is just a different way of expressing the same thought. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view… The above standard is the test for which a doctor's function of diagnosis and treatment is considered.[130]

Notwithstanding, the position of the court in Bolam's case has been varied by the decision in *Bolitho (Deceased) v. City and Hackney HA*[131] Unlike Bolam's case, the court held that the judge is entitled to choose between two bodies of expert opinion depending on which is logically defensible. Thus, the court is obliged to pick an opinion of a body of experts that it logically aligns with in so far as it is reasonable and logical, and it is no longer sufficient for there to just be a body of experts that agree with the method adopted by the defendant. However, it is pertinent to note that it is practically impossible for a medical practitioner to know all the up-to-date methods in determining what methods the courts will align with as reasonable and logical.

Further development in the United Kingdom has been made with the emergence of the case of *Montgomery v. Lanarkshire Health Board*,[132] where the court deviated from the position in Bolitho by stating that in the context of patient decision-making, it is not sufficient to act by a reasonable body of expert opinion, there is a duty on the medical

[130] Abi (n 127) (Nwodo JCA) (39 - 40 Paras B - A).

[131] [1998] AC 232.

[132] [2015] UKSC 11

practitioner to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. Hence, if a risk is material to a patient, the patient must be afore warned by a medical professional of the treatment options available to them. The case of Montgomery places an additional burden on healthcare professionals to disclose all material risks of a potential treatment or other suitable alternative before administering such treatment to the patient, providing a patient- centred approach to providing medical care.

Conversely, in the Nigerian case of Okekearu *v. Tanko*[133] the appellant sued the respondent for negligence after suffering harm from the negligent amputation of his finger, an action that permanently disfigured and incapacitated the appellant in handling objects. The court ruled in favour of the appellant, adopting Bolam's principle and emphasising that consent is permissible if it aligns with established professional and medical standards. However, it fails to recommend a patient-centred approach that facilitates the disclosure of all material risks, allowing the patient to determine which risks they are willing to accept. This case was a missed opportunity to develop the Nigerian medical law jurisprudence in a manner that formally recognises the duty to disclose material facts and uphold informed patient choice.

Given the shortage of medical resources in Nigeria's healthcare system, especially in remote areas, should doctors be held liable for negligence due to insufficient resources? The American court addressed this question in the case of *Warnock v Kraft,*[134] which

[133] [2002] 15 NWLR PT 791, 657.

[134] [1938] 85 CA.

determined that a doctor in a small community or village, lacking the same opportunities and resources or failing to keep up with advancements in the profession, should not be held to the same standard of care and skill as physicians and surgeons in larger cities.

Although there are few other cases in Nigeria that discuss the breach of medical duty, they exist, nonetheless. For example, in the Nigerian case of *Adebayo v. Chairman, MDPIP & Ors*,[135] the Appellant appealed the decision of the Medical and Dental Practitioners Disciplinary Tribunal following the death of a patient who had undergone a caesarean section and bilateral tubal ligation but died post-surgery due to a lack of blood transfusion. The deceased's husband refused the blood transfusion, and the Appellant did not take any further steps to transfer the patient or to advise on alternative medication or treatment, if applicable. The tribunal found the Appellant liable for allowing the surgical operation on the deceased patient to be conducted by sub-consultant staff under his training and for failing to establish an alternative line of treatment for her. Although the Court of Appeal stated unequivocally that the Appellant could not be regarded as having delegated the operation to the sub-consultant, as he was present during the procedure, it did not hold the Appellant accountable for failing to recommend the transfer of the deceased or to suggest alternative medications and the implications of refusing a blood transfusion. This case suggests that the court's failure to adopt the Montgomery approach led to a different outcome that practically disregarded the medical practitioner's responsibility to provide informed consent or disclose information to patients and their families. The practice of informed

[135] [2018] LPELR-45537 (CA). In the case of Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo (2001) WRN 1, the Supreme Court held rightly that a patient has the right to accept or reject a particular form of treatment if they are a competent adult, including refusing lifesaving treatment on religious grounds thereby choosing a path that may ultimately lead to his death, especially in the absence of judicial intervention is most unlikely.

consent within the Nigerian healthcare system is beneficial, as it enhances patient safety and holds medical practitioners accountable. It will also educate patients about the risks associated with the proposed treatment, potentially preventing initial and compounded harm.

In the case of the *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo,* a patient refused a blood transfusion or any blood products and signed an undertaking stating that blood should not be transfused to her under any circumstances for religious reasons. This patient had made a similar choice at a previous hospital before being transferred to the respondent's facility. The respondent accepted the undertaking and declined to administer a transfusion, ultimately leading to her death. The Apex Court in Nigeria ruled that the medical opinion regarding what is best for the patient must not overshadow the patient's right to decide whether to accept the offered treatment. The patient retains the freedom to accept or reject treatment recommended by a physician. If a doctor makes a well-balanced recommendation for a surgical procedure, the patient has the right to refuse that advice for reasons that may be rational or irrational. Nonetheless, it is my considered opinion that although medical practitioners must disclose material risks and the nature of any proposed medication or treatment and such disclosure should not absolve them from liability where harm results from negligent performance, as opposed to harm arising solely from an inherent and disclosed risk of the treatment.. Further, the court failed to interrogate the 'standard of care' test regarding whether the doctor exhausted all other alternatives to blood transfusion and the liability that may ensue thereafter or proactively obtaining an emergency court order to override patient autonomy. Whilst the case reinforced the patient's autonomy, especially considering the right to religion, in the best interest of the

patient it failed to assess whether the patient fully understood the decision taken as it was a life-threatening case and the responsibility of the doctor in this case.

In the English case of *Darnley v. Croydon Health Services NHS Trust*,[136] an NHS trust was held responsible for misleading a patient regarding waiting times by its receptionists. The receptionist informed the patient that he would have to wait four to five hours to see the doctor but failed to mention that he would be triaged within thirty minutes. Based on this information, the patient waited 19 minutes before leaving, and shortly after arriving home, his health deteriorated, resulting in permanent and serious injury. The Supreme Court held that the hospital had breached its duty of care to the patient due to the receptionist providing inaccurate waiting time information. The court added that the standard required is that of an averagely competent and well-informed person performing the role of a receptionist in a department providing emergency medical care. Therefore, it is important to note that medical practitioners may be vicariously liable for the acts and omissions of their non-medical staff. However, this is not the case in Nigeria, where the fault of the alleged practitioner must be established rather than that of an administrative staff member.

In the case of *Robinson v. Chief Constable of West Yorkshire Police*[137] two police officers, while pursuing a drug dealer, fell onto the claimant, an older woman, who subsequently sued for negligence. Although the police officers contended that they were immune from liability for negligence while exercising their powers of investigation or

[136] [2018] UKSC 50.
[137] [2018] UKSC 4.

crime prevention for public policy reasons, the Supreme Court found the officers liable for negligence due to the foreseeable risk of injury to bystanders. While Robinson's case is not a medical negligence case, the principles established by the Supreme Court influence the development of the duty of care in medical settings. For instance, the court established that a duty of care is owed once the harm is deemed reasonably foreseeable. Consequently, in healthcare settings, medical practitioners are liable for reasonably foreseeable harm in the delivery of care. This principle supports patients with claims for medical negligence, aiding in the establishment of liability for medical practitioners and expanding the duty of care beyond the confines of the patient-doctor relationship.

Furthermore, it reinforces the claims made by relatives of individuals affected by medical negligence. They are entitled to bring third-party claims as reasonably foreseeable recipients of the harm caused to the patient by negligent treatment. These English cases have advanced in defining what constitutes medical negligence for both medical practitioners and the NHS.

2.3.4 What is the Damage resulting from the breach of the medical duty of care (Causation)?

Establishing damage is the crux of establishing a case of medical negligence. A patient who has experienced medical negligence must establish that the causal factor for the injury or damage complained of is a result of the doctor's actions and/or omissions. Additionally, the damage suffered need not be a direct outcome of the medical practitioner's actions,

such as physical injuries, amputation, or death; it may also be indirectly construed, such as loss of means of livelihood, reduced life expectancy, or diminished quality and enjoyment of life due to the damage caused. Where the damage is direct and apparent, the *res ipsa loquitur* principle is applied. For instance, in the case of *Igbokwe v. University College Hospital Board of Management*,[138] the principle of *res ipsa loquitur* was invoked regarding the fatal injuries sustained by a woman who had just given birth and had been diagnosed with psychosis. After receiving a sedative, she fell from the fourth floor of the hospital building due to the failure of the nurse on duty to monitor her as instructed by the attending doctor. Although the patient's health had initially improved following childbirth, the hospital acknowledged that the lack of proper supervision contributed to the incident. The hospital was held accountable for a breach of duty of care with respect to the actions and omissions of their staff.

Premised on the above, the complexity of proving that patients' injuries result from negligence is considerable. Patients cannot determine the existence of medical negligence independently without first supplying evidence (typically through the testimony of another medical practitioner) to the court. The professional solidarity among medical practitioners encourages reluctance to testify against their colleagues. This camaraderie presents a challenge in securing expert witnesses to substantiate patients claims. This situation has been termed the 'conspiracy of silence.'[139] As a result, it has dissuaded patients from filing

[138] [1961] W.N.L.R 173.

[139] SI Salihu, 'The Need for Expert Witness in Medical Malpractice Suits and the "Conspiracy of Silence'' (2022) Journal of the Nigerian Bar Association Kano Branch 2019. <www.researchgate.net/publication/362986277_The_Need_for_Expert_Witness_in_Medical_Malpractice_Suits_and_the_Conspiracy_of_Silence_Journal_of_the_Nigerian_Bar_Association_Kano_Branch_2019> accessed 1 December 2024

claims, as an increasing number of professionals are hesitant to support claims against their peers, especially since no regulations or codes prevent doctors from testifying against a colleague.[140]

Additionally, the challenges of proper documentation of patients' data and medical records have made seeking justice under the tort system in Nigeria a herculean task. For example, it is almost impossible for patients to collect their data and relevant medical records to support their litigation claims because these data are not readily accessible and available to the patient or their families.[141] As observed by Kamourudeen, patients in Nigeria are routinely denied access to basic information about their diagnosis and treatment.[142]

Furthermore, the shortage and idolisation of medical practitioners lead to patients' reluctance to pursue claims related to medical negligence. Occasionally, these biases can influence court decisions due to the significant reverence that medical practitioners enjoy, stemming from the inadequate number of practitioners available to meet the population's care needs.[143] Indeed, the scarcity of medical professionals in Nigerian hospitals has resulted in systemic negligence, causing delays and denial of patient care. Additionally, the portrayal of medical practitioners as 'mini-gods' is likely to deter their accountability, particularly when claims often favour them as individuals who are seen as either blameless

[140] Ibid.

[141] Adegboyega (n 100) 7.

[142] Ibid.

[143] For example, there has been a continuous fear that the governed-owned hospitals may become empty due to brain drain, among other reasons. Nicholas Kalu, 'Brain drain: Our hospitals may soon become empty, CMDs cry out' (21 July 2025) <https://thenationonlineng.net/brain-drain-our-hospitals-may-soon-be-empty-cmds-cry-out/#> 21 January 2025.

or incapable of making mistakes.[144] In Nigeria, there exists a culture that depicts doctors as among the few who attain extraordinary educational prestige, typically reserved for the upper echelons of society, rendering them indispensable assets. This mindset fosters the belief that medical practitioners are infallible and perceived as possessing superior intellect, skill, and expertise. Consequently, this reasoning discourages patients who have endured medical negligence from seeking their legal rights, compounded by the challenges presented by the tort system.

The points above have prompted the development of procedural initiatives within a broader context to provide compensation for victims of medical negligence and to address patients' underlying needs. Given the complex nature of the Nigerian healthcare system, it is crucial to explore alternatives to the tort system of medical negligence. The following sections will examine the inadequacies of the tort system and the statutory rights of patients suffering from medical negligence in Nigeria, aiming to determine whether the tort system effectively holds medical providers accountable for instances of medical negligence through an analysis of patient's rights, the jurisprudence surrounding medical negligence, and the role of the Medical and Dental Council of Nigeria.

2.4 The Inadequacies of the Nigerian Tort System

The tort system remains the primary means by which negligence claims are resolved in most countries across the globe, including Nigeria. However, as this chapter and

[144] R O Olorunsuwa, et al., 'Medical Challenges of Healthcare Delivery in Nigeria: A review of Some Selected Cases' (2022) 4 (1) Global Journal of Health Related Researches 148.

subsequent chapters will demonstrate, this system has several deficiencies that fail to address patients' safety and physicians' responsibility.

There have been a few reported cases of negligence in Nigeria for several reasons, some of which are the lack of faith in the legal system and socio-cultural factors such as unfavourable outcomes for patients due to difficulty in proving the practitioner's fault.[145] Further, evidence shows that many persons who have experienced medical negligence have shown reluctance in seeking legal redress due to the delays that encumber the litigation process, making it difficult, unappealing and often a 'waste of effort.' Additionally, the apathy in pursuing a medical negligence claim is tied to the low legal awareness of patients' rights due to Nigeria's literacy levels and prevailing cultural factors. These factors all tie into making torts an unappealing resolution model for patients. Nonetheless, evidence has shown that most patients who suffer harm in institutional healthcare settings are interested in knowing that someone has taken responsibility for the incident.[146]

Consequently, the subsections below briefly discuss three significant shortcomings of the tort system in Nigeria and its effects on patients and physicians impacted by incidents of medical negligence. These subsections are:

[145] Babafemi Odunsi, 'Medical Negligence and its Litigation in Nigeria,' (2023)14 (2) Beijing Law Review 1090.

[146] Iyioha (n 12).

2.4.1 Delayed Justice

Many patients and physicians involved in medical negligence incidents are affected by the adversarial nature of the tort system, which is compounded by bureaucracy and a delayed justice system. Patients and medical practitioners involved in a lawsuit must bear the burden of hiring a lawyer and navigating the litigation process, often fraught with procedural delays. For instance, Bastiampilli et al. stated the following:

> A case may be delayed at every stage for all sorts of excuses such as a delay in filing the statement of claim or defence, the judge is absent, late delivery of medical reports and more… in Dr Chin Yoon Hap v. Ng Eu Khoon & Ors & Other Appeals [1998] 1 CLJ 533, the case was initiated on 23.12.1981 and the final judgment was delivered 7.11.1997, it took 16 years to be decided. [147]

Furthermore, in his publication titled 'Justice Delayed,' Heal reported that a filed suit took 'nearly 400 court hearings and 23 years only to receive RS 50,000...'[148]

In Nigeria, a medical case was taken to court in 1997, and the judgment and final resolution of the matter were delivered in 2019, resulting in a two-decade resolution period. In the case of *Tega Esabunor & Anor v. Dr Tunde Faweya & Ors*.,[149] the second Appellant, the mother of the first Appellant, gave birth in April 1997. Within a month, the first Appellant fell ill and required urgent treatment. The doctor advised that a blood transfusion

[147] Andriea Bastiampillai, Mohammed Hamid and Nor Wahab, 'The Implementation of Mediation in Medical Negligence Disputes in Malaysia' (International Conference on Law and Global Faculty of Law and International Relations, Universiti Sultan Zainal Abidin, October 2018) 246.

[148] Heal India, 'Justice delayed' (HT Syndication 2015) cited in Bastiampillai et al. (n 145).

[149] [2019] 7 NWLR Pt. 1671 316.

should be performed due to the severe infection and anaemia the baby was suffering from; however, the mother did not consent because of various health risks such as AIDS and hepatitis. Despite her refusal, the blood transfusion was carried out under a court order. This case was initiated in 1997 and was finally resolved in 2019; it exemplifies the delays and inefficiencies of the tort system.

Furthermore, the highly publicised case of a renowned baker based in Lagos, who tragically lost her life due to alleged medical negligence at one of Nigeria's leading hospitals, remains unresolved. Despite attracting significant media attention[150] and the involvement of numerous lawyers, Peju Ugboma, an award-winning founder and CEO of I Luv Desserts, passed away following fibroid surgery in April 2021. Nevertheless, her family continues to seek clarity regarding the circumstances surrounding her death, as no individual has yet been held accountable by the courts. Following her passing, an independent autopsy was conducted at the Lagos State University Teaching Hospital by pathologists, revealing that she had died from internal bleeding; approximately 2 litres of blood were found in her abdomen and pelvic area due to the negligent surgical procedure. Although this incident occurred over a year ago, the professional tribunal has yet to reach a conclusion about the liability of the medical practitioners involved, nor has the court issued a definitive ruling on the matter.[151] This delay is attributable to the lengthy litigation processes and the complexities of the traditional tort system, coupled with the challenge of

[150] Oluwakemi Adelagun, 'Peju Ugboma: Medical council indicts Premier hospital doctors' (10 November 2021) <www.premiumtimesng.com/regional/ssouth-west/494619-peju-ugboma-medical-council-indicts-premier-hospital-doctors.html> accessed 15 September 2022.

[151] Oluwakemi Adelagun, 'Peju Ugboma: Premier Hospital doctor, accused of misconduct, testifies' (14 March 2022) <www.premiumtimesng.com/news/more-news/517255-peju-ugboma-premier-hospital-doctor-accused-of-misconduct-testifies.html> 25 October 2022.

proving the three elements of medical negligence in court and other litigation-related factors. Importantly, the delays in the justice system that patients frequently encounter when pursuing claims serve as compelling reasons for individuals to feel dissuaded from seeking justice through the traditional tort system.[152] Tumelty noted, 'Over recent decades, litigation has been portrayed as particularly ill-suited to medical negligence disputes due to its aggressive and adversarial nature.'[153]

Further, the delay accompanying the litigation process often affects patients and physicians in various ways. Studies have suggested that the 'litigation process causes or exacerbates harm, from the perspective of both the plaintiff and the medical practitioner.'[154] As a result, policies addressing tort system reform have focused on the need for alternatives to litigation as a means of redress. For example, in the Nigerian context, the Nigerian Health Insurance Act of 2022 makes provisions for the settlement of medical negligence disputes through arbitration, mediation, and negotiation. However, a recent study in 2019 indicated that although 'parties may, if they express the wish to do so, give jurisdiction to arbitrators to settle their disputes, but on the other hand, the state retains the power to prohibit settlement of certain categories of disputes outside its courts.'[155] Hence, until the State decides otherwise, the statute is not enforceable.

Thus, the only guaranteed way to dispute medical negligence claims is through the tort

[152] Okanyi and Guruje (n 102).

[153] Mary-Elizabeth Tumelty, 'Exploring the emotional burdens and impact of medical negligence litigation on the plaintiff and medical practitioner: insights from Ireland' (2021) 41(4) Legal studies (Society of Legal Scholars) 633.

[154] Tumelty (n 153).

[155] A T Bello, 'Arbitrability of Medical Negligence; The Need for Urgent Action' (2019) 28(3) Nigerian Journal of Medicine 310.

system, which cannot be prohibited by the states. In light of this, the rigorous process of proving medical negligence coupled with the complexity of the arbitration procedure requires a re- evaluation of the system and the provision of a patient-centred model for the resolution of medical negligence disputes.

Furthermore, evidence from the international body of literature has demonstrated that delays during the litigation process 'often have profound and long-lasting emotional consequences for plaintiffs.'[156] There is also a consensus among scholars regarding the concept of litigation-induced harm, this is supported by Less-Haley's argument that 'where a plaintiff experiences a group of symptoms such as anxiety, anger, and depression, which result from litigation–induced harm, these symptoms may collectively be recognised as litigation-response syndrome.'[157]

Moreso, the waiting period imposed on both patients and medical practitioners while awaiting the outcome of a judgement creates a traumatic and devastating experience that they must relive. It has been argued that the impact of this delay varies, affecting both the patient and the medical practitioner in different ways. For example, research conducted in Ireland highlights that 'it is more difficult to quantify the impact of prolonged litigation on the psychological well-being of the plaintiff.'[158] Likewise, Ryll's argument regarding the impact of litigation on medical practitioners suggests that 'litigation causes a tremendous amount of personal exposure to medical practitioners, and emotional wounds are kept open

[156] Tumelty (n 153).

[157] Ibid.

[158] Ibid.

by the long and arduous litigation process, delaying healing.'[159] Ironically, in Nigeria, there has been a dearth of literature on patients' and medical practitioners' opinions about the adversarial process; this is likely due to patients' socio-cultural and religious views. To bridge this gap, it is suggested that future research should focus on patient and medical practitioners' satisfaction with the adversarial system to determine whether the tort system in Nigeria can be improved. This is necessary to inform policy on administrative mechanisms and alternatives to litigation that can be adopted to ensure speedy and efficient resolution while at the same time minimizing harm to both parties.

2.4.2 Patients Search for Information

The tort system's adversarial nature overlooks patients' questions after harm has occurred, as they must provide evidence (fault) to win their claims in court. This applies to situations where patients pursuing a claim are compelled to wait an extended period for a final judgment. For example, as noted by Okanyi and Guruje, 'in Plateau State, *Health Services Management Board & Anor v. Goshwe,*[160] an injury that occurred in August 1990 was not settled until 2012 when the Supreme Court gave a final judgement in the matter.'[161]

Patients who experience harm are searching for information while awaiting court decisions, but the tort process often overlooks their inquiries due to the adversarial nature of the justice system. According to Wailing et al., patients need to engage with a commitment to foster a better and more transparent relationship between healthcare

[159] Ibid.

[160] [2012] LPELR-9830 (SC).

[161] Okanyi and Guruje (n 102).

providers and other stakeholders.[162] Indeed, the initial harm is further exacerbated when patients, after suffering harm, need to express their pain and anger about what occurred; instead, they are left to cope with the frustrations of the traditional tort system.

Preventing harm at the initial stage has become a recent focus for policymakers and scholars in the field through the advancement of patient safety initiatives. A key development occurred in 2009 when the WHO acknowledged the significant harm inflicted on patients by investing in an international classification system for patient safety.[163] While this development is crucial for improving the global system to mitigate risks and prevent initial harm, it is highly pertinent for policymakers in Nigeria to adopt alternative models to the tort system that have been established in other jurisdictions with comparable legal histories.

Furthermore, research into the experiences of both patients and physicians with the tort system indicates that 'more often than not, both sides (healthcare providers and patients) left the legal process feeling dissatisfied; even successful claimants voiced grievances about the absence of an apology, an explanation of the event, or any assurance that lessons had been learned.'[164] Although countries have recognised the damaging nature of the adversarial system, there has been a concerted effort within the healthcare setting to achieve reconciliation, improve communication between patients and physicians, offer an

[162] Jo Wailing, Chris Marshall and Jill Wilkinson, 'Hearing and responding to the stories of survivors of surgical mesh: Ngā kōrero a ngā mōrehu – he urupare' (A report for the Ministry of Health 2019) Wellington, New Zealand: The Diana Unwin Chair in Restorative Justice, Victoria University of Wellington <www.health.govt.nz/system/files/2019-12/responding-to-harm-from-surgical-mesh- dec19.pdf> accessed 22 October 2022.

[163] Ibid.

[164] Ian R Barker, 'Is a 'No-Fault' Compensation Scheme the Answer to the Problems of Tort in Clinical Negligence?' (2015) 34(1) Medical Law 595.

apology or compensation, and facilitate healing from the incident. However, this is not the case in Nigeria.

Effective patient-physician communication is critical to determining whether Nigeria's tort system can be reformed. Therefore, standards and procedures based on these principles will provide truthful explanations to patients and their families when errors occur. Establishing an advocacy service is integral to raising awareness about patients' right to complain and providing knowledge on access to justice.

2.4.3 Blame Culture

The tort system of medical negligence in Nigeria centres on professional regulation and emphasises the punishment of individual physicians. However, while the tort system aims to address the faults of physicians, the regulations do not take into account the systemic factors that contribute to medical harm. As a result, physicians face stigmatisation, which subsequently leads to defensive medicine, discouraging open dialogue and discussion about the factors contributing to medical errors and the potential to learn from these situations. For instance, doctors may order unnecessary tests to pre-empt potential lawsuits, prioritising self-protection over patient welfare and safety, and these do not serve the patient's best interests.[165]

In this context, scholars have advocated for a cultural shift within the healthcare setting, moving from a punitive and adversarial culture of blame towards a relational, supportive,

[165] Miziara and Miziara (n 107); Amitabh Chandra, Anupam B Jena and Seth A Seabury, 'Defensive medicine May be Costlier Than it Seems' (2013) Wall Street Journal <www.wsj.com/articles/SB10001424127887323701904578280112638373302> accessed 12 September 2022.

and collaborative system that aims to empower patients and physicians. For instance, Iyioha noted that 'calls have been made for tort reform and the establishment of an administrative system to address patient safety and accountability.'[166] Given this, there is an urgent need for healthcare reform in Nigeria that upholds the principles of collaboration, non-adversarial approaches, and education, which should be integrated into existing alternative models to enhance the safety and accountability of physicians. This will inform policy and legislation in Nigeria in determining whether an alternative, for example, a no-fault system, can better facilitate better redress for persons who have experienced medical negligence than the tort system in Nigeria and existing alternative models and how it might work in practice.

Furthermore, specific conduct per existing laws[167] constitutes professional negligence in Nigerian healthcare, often attracting three penalties from the medical tribunal: admonition, suspension, or removal from the register of practitioners.[168] This indicates that the system primarily operates on blame culture and pays scant attention to patient compensation. As Olaniyan pointed out, 'the objective of the trial before a disciplinary tribunal is to punish the erring medical practitioner, not to compensate a victim as occurs when an action for medical negligence is taken in the civil court.'[169] This underscores the dissatisfaction patients have with the tort system. Thus, the various initiatives available as alternatives to

[166] Iyioha (n 12).

[167] This can be found in the Nigerian Code of Medical Ethics 1988.

[168] See The Medical and Dental Practitioners Act 1988, s. 16 (2) (a), (b) and (c).

[169] HA Olaniyan, 'Liability for medical negligence in Nigeria' (2005) 4 (2) Nigerian Journal of Health and Biomedical Sciences 169.

the tort system in Nigeria should be integrated with a framework that addresses systemic issues and compensates patients without necessitating proof of fault on their part.

2.5 Limitations of the Nigerian Tort System in Summary

It is evident that cases of medical negligence are sparse in Nigerian courts due to the complex elements of negligence, which causes patients to relinquish their rights to litigate or pursue a claim, along with various socio-cultural factors. Consequently, alternatives to this system are being sought. These alternatives, including the no-fault system, restorative approach, operational arbitration, mediation, and negotiation, are discussed in the subsequent chapters of this thesis.

Furthermore, research evidence has shown that patients are more concerned with honesty and explanations from healthcare providers and institutions, which appears to be the reason they pursue litigation in the first place.[170] Additionally, when patients experience harm, the reluctance of medical practitioners to take responsibility and provide crucial answers about what occurred leaves patients with no choice but to seek justice through litigation. However, due to its adversarial nature, the litigation process fails to provide honest answers and explanations regarding what transpired.

While patients seem to value healthcare providers taking more responsibility for their actions, the law governing medical negligence in Nigeria currently emphasises punishing practitioners. It also remains silent on how patients will receive appropriate compensation

[170] Iyioha (n 12) 62.

and recover after their negative experiences with the healthcare system, thereby underscoring the shortcomings of the existing fault-based system.

Conversely, other alternatives to the tort system have been adopted in different countries. For example, in New Zealand, there are restorative processes that are being used when incidents of medical negligence occur, and a trained facilitator organizes a meeting between a patient, medical practitioners, and their family members to talk about what has happened and to do something about it by way of compensation to the patient and bringing medical practitioners to truly understand the impact of their actions by offering an apology to foster reconciliation and healing for all parties involved.[171] This process emphasises the need for apology and healing for all parties involved.

It should be noted that this research aims to explore alternative processes to the Nigerian tort system and ascertain essential characteristics of systems that could be adopted and integrated into the Nigerian regulatory framework.

The above highlights a challenge in pursuing remedies available to patients who have experienced medical negligence in Nigeria. Therefore, there is an urgent need to re-evaluate the tort system to seek justice for patients, alongside compensation schemes that patients can benefit from in cases of medical negligence.

2.6 Statutory Rights of Patients Who Suffer from Medical Negligence in Nigeria

[171] This is discussed in more detail in Chapter 3.

In Nigeria, the medical rights of patients are legally entrenched, providing the foundation for pursuing medical negligence claims via a combination of legislation, regulatory frameworks, and professional codes. However, a common issue within these laws is the challenge of implementing and translating these black-letter legislation into actionable outcomes that address the needs of patients, particularly those who have experienced medical negligence.

Patients who have experienced medical negligence in Nigeria have procedural and substantive rights to pursue claims. Some of the substantive laws include the Constitution of the Republic of Nigeria 1999 (as amended), the National Health Insurance Act 2022, the Patients' Bill of Rights,[172] and statutes regulating professional practice in Nigeria, such as the Medical and Dental Practitioners Act 1988, and the Nursing and Midwifery Act 1979, along with the Code of Medical Ethics 1988, among others. Conversely, procedural laws are governed by various court procedures employed across the different courts in Nigeria, including the Evidence Act 2004 and the Arbitration and Mediation Act 2023. It should be noted that it is impractical to detail all these pieces of legislation; therefore, the focus will be on key laws that have a direct bearing on medical negligence, particularly regarding medical practitioners.

Firstly, the Nigerian Constitution, as the *grundnorm,* serves as the foundation for patient's legal rights. It is important to note that Section 17(3)(d) of the Nigerian Constitution stipulates that the State (Government) shall direct its policies to ensure the availability of

[172] This was developed by the Consumer Protection Council of Nigeria, an agency of the Federal Government of Nigeria mandated to protect the Nigerian people, and the Federal Ministry of health to protect consumers (patients).

adequate medical and health facilities. This implies that every Nigerian citizen has the right to health and access to sufficient medical and health services. However, significant inadequacies persist within the medical system (as discussed in Chapter 1). Additionally, the right provided under Section 17 (3) (d) is under Chapter 2 of the Constitution. However, Chapter 2 of the Constitution has been argued to be unenforceable, as Section 6(6)(c) of the Nigerian Constitution renders it impossible for patients to enforce their rights in court. Therefore, while these constitutional rights exist, their implementation is limited,[173] further restricting the remedies available to patients. The legislation is akin to a dog that can bark but cannot bite.

Another rule is the Code of Medical Ethics 1988 in Nigeria, applicable to all medical and dental practitioners registered under the Medical and Dental Practitioners Act,[174] which provides that patients have the right to be adequately attended to, the right to consent or reject a form of treatment, the right to be treated with the utmost care, and the right to privacy of the privileged information shared by patients with their medics, among others. Notwithstanding, these rights are unenforceable because the code does not provide mechanisms for aggrieved patients to enforce these rights.

Closely related to the Code of Medical Ethics 1988 is the Patients' Bill of Rights (PBoR),[175] which attempts to protect patients. However, it is a subsidiary regulation that is

[173]Priscilla Ngozi Nnawuba, 'Non-Justiciability and Enforceability of Chapter II of the Nigerian Constitution as an impediment to enjoyment of economic Rights and Development' (2022) 6(2) African Journal of Law and Human Rights 149; O. Olumese, 'Duty without liability: The impact of article 12 of the International Covenant on Economic, Social and Cultural Rights on the right to health care in Nigeria' (2021) 21 African Human Rights Law Journal 1112; R N Nwabueze 'The Legal Protection and Enforcement of Health Rights in Nigeria', in C.M. Flood and A. Gross (eds.) *The Right to Health at the Public/Private Divide: A Global Comparative Study.* (Cambridge, Cambridge University Press, 2014) 371.

[174] Cap M8 Laws of the Federation (LFN) 2008.

[175] Federal Competition & Consumer Protection Commission, 'Patients; Bill of Rights' <https://fccpc.gov.ng/wp-content/uploads/2023/04/PATIENTS-BILL-OF-RIGHTS-ILLUSTRATED-GUIDE.pdf> accessed 1 January 2025.

ineffective and/or unenforceable. It is secondary legislation and can only be adequately enforced when it is made primary legislation and recognised by the professional regulators in Nigeria. Consequently, the medical practitioners' professional regulation is reviewed below vis-a-vis the regulators' duty.

2.6.1 What is the role of the Nigerian Medical and Dental Practitioner's Council?

Section 1 of the Medical and Dental Practitioners Act 1988 established the Medical and Dental Practitioners Council, which oversees the operations of the Nigerian medical and dental professions. Although the organisation enforces strict compliance with its rules and regulations, it has faced significant criticism from the public regarding the absence of statutory provisions that directly compensate patients for medical negligence.

Further, section 15 of the Medical and Dental Practitioners Act 1988 establishes the disciplinary tribunal by the council on the principles of the tort system, which is paramount to the medical practitioner's responsibility to demonstrate that the reasonable standard of duty of care towards the patient who has lodged a complaint with the panel has not been breached. Cases are typically referred to the Tribunal by the Investigative Panel, and a report is submitted to the President of the Council, who will determine whether the Tribunal will be convened. It is important to note that the tribunal functions similarly to a courtroom and can declare a practitioner in breach of professional standards which could ultimately result in removing their name from the registry or suspending the doctor from practice. This punitive approach has been observed as potentially increasing the likelihood

of the practice of defensive medicine, where practitioners become more focused on protecting their careers than on patient care.[176] Furthermore, the system is founded on punishment, guilt, and shame, which can adversely affect the self-esteem of medical practitioners and may ultimately lead to alienation from the community, especially in severe instances of medical errors resulting in patient fatalities.

One of the aims of this research has been to inform policy regarding the enactment of a negligence law parallel to a no-fault regulation with an integrated restorative justice approach. Suppose cases brought before the disciplinary committee are referred for an intervention seeking redress for the patient and providing therapeutic and social support to all parties in an out-of-court setting. In that case, the outcomes of the claims will be significantly better than those of the current tort system. For instance, outcomes that address individuals' needs may include restoring trust, fostering recovery for all involved, and offering an apology that meets those needs, which may encompass compensation, healing, and learning. This can be accomplished through restorative practices such a facilitated meetings, circles, and restorative conversations that involve storytelling and listening, supported by skilled facilitators. Additionally, the cooperation and accountability of medical practitioners participating in initiatives focused on healing, apology, and compensation should be rewarded when determining breaches of the expected standard of care by the Medical and Dental Practitioners' Disciplinary Committee. Furthermore, opportunities should be provided for practitioners reasonably proven negligent in rectifying the harm

[176] Babafemi Odunsi, 'Medical Negligence and its Litigation in Nigeria,' (2023)14 (2) Beijing Law Review 1090; A Adejumo and A Adejumo, 'Legal perspectives on liability for medical negligence and malpractices in Nigeria' (2020) 35 The Pan African Medical Journal 1.

caused through treatment programmes, professional training initiatives, and the chance to earn permanent certification to continue their practice.

2.7 Existing Alternatives to the Tort System in Nigeria

As discussed earlier, patients are presented with existing alternatives to the tort system for pursuing a claim of negligence, specifically through arbitration, mediation, and negotiation. This section explores these alternatives to determine whether they are patient-centred and can effectively and efficiently meet patients' needs in accessing justice.

While patients can seek compensation through tort law, such as litigation, they can also now seek redress through alternative dispute resolution techniques, such as arbitration, mediation, and negotiation. The National Health Insurance Act 2022 makes provisions for using alternatives to the tort system in medical negligence cases. This legislation is good progress, as lessons can be learned from successful interventions implemented in other jurisdictions. However, as of today, its value is untapped and inaccessible to patients due to implementation bottlenecks.

Notwithstanding, developing alternative models to resolve medical negligence disputes would encourage patients who suffer harm to pursue justice. This approach will also shorten the lengthy waiting period for trials and help address the lack of research on the experiences of both patients and medical practitioners, informing policy and research regarding their satisfaction with alternatives to the tort system in Nigeria.

Many countries have now shifted from the tort system to the practice of alternative dispute resolution to settle medical negligence disputes. For example, Sohn noted that ‘two

notable success stories include the mediation programs at Dresel and the University of Pittsburgh which indicates they have reported 85% and 88% successful resolution of conflicts without litigation respectively.'[177] Similarly, Kachalia purported that 'each of the Nordic countries has abandoned their negligence-based compensatory systems at different times over the last 30 years.'[178]

However, implementing these alternatives now available in Nigeria is subject to the restrictions set out in the Arbitration and Mediation Act 2023 which states that arbitration cannot be used unless parties agree in writing to rely on arbitration.[179] Although s. 2(4) of the 2023 Act expands the definition of writing to include electronic communications and agreements formed through digital means, unlike the repealed Arbitration and Conciliation Act (ACA), which merely states in s. 1(1) that 'parties to the arbitration must have an arbitration agreement in writing before submitting to arbitration… this requirement is fulfilled if the arbitration agreement is contained in a document signed by both parties.' In other words, if either of the parties involved in a medical claim refuses to sign the arbitration agreement, the parties cannot submit to arbitration.

In addition to arbitration, there are also avenues to explore mediation and negotiation. Despite these options. Particularly, s. 70(3) provides that any party can propose to the other party's recourse to mediation, regardless of all other judicial or arbitral proceedings, before, during or after the initiation of the judicial proceedings. However, these options

[177] Sohn (n 7).

[178] Allen B. Kachalia and others, 'Beyond negligence: Avoidability and medical injury compensation' (2008) 66(2) Soc Sci Med 387.

[179] See Arbitration and Mediation Act 2022, s 2(2). This is the same as the provision of the repealed Arbitration and Conciliation Act, 2004, s 1.

raise the question of whether decisions reached at the mediation and negotiation are binding on parties and enforceable, especially when there is no formal agreement between the parties to be bound by mediation.

Relatedly, the cost of exploring arbitration is another inhibiting factor for patients who may want to explore the option. Arbitration is quite expensive, as parties must agree on how the arbitrator would be paid, unlike judges who are paid by the State.

Furthermore, the Arbitration and Mediation Act does not provide for third-party funding, which the parties—in this case, patients and medical practitioners—might use if they choose to pursue arbitration.

Additionally, implementing the alternatives provided is slow-paced because of systemic barriers, such as patients not being aware of these alternatives. Patients are not always aware or informed about seeking redress when they experience harm. Other barriers include the procedural bottlenecks of activating the alternatives provided, which are still premised on tort—showing the practitioner's fault in justifying the action.

Further, the Nigerian public depends largely on public health facilities due to the poverty levels of the citizenry, which are already less funded. The bureaucracy of getting the hospital or medical practitioner to mediation or arbitration is tedious, or even signing an arbitration/mediation agreement is near impossible. This may be due to many patients being admitted in an emergency, the literacy levels of patients, and socio-economic and cultural factors.

Other issues with the alternatives provided hinge on the enforceability of the decision reached, assuming without conceding that arbitration or mediation is explored. Usually, an order of court must still be obtained to enforce an arbitral award. This then defeats the purpose of not exploring litigation (tort).

Notwithstanding, patients must always show fault in their approach to seek compensation. Section 131 of the Evidence Act, 2004 provides that whosoever asserts must prove. The fault pre-requisite is ingrained in the adversarial nature of dispute resolution in Nigeria. With the practice of defensive medicine, it is unlikely patients will be able to scale this.

2.8 Adopting Alternative Systems of Redress

When a patient succeeds in a negligence claim against a medical practitioner, compensation is usually sought from the practitioner directly, from the hospital where the procedure occurred, or from their insurers. Although exemplary damages may be awarded, the primary purpose of damages is compensation or restorative justice, aiming to restore patients to their pre-procedure circumstances or to a relatively similar situation.[180]

The complex nature of the tort system, together with its impact on patients, discourages litigation. For example, delayed justice systems for patients and physicians often lead to emotional and mental distress. It is also argued that the fact that a patient is successful in a claim does not necessarily mean that they are satisfied with the outcome because the

[180]Eric Okojie 'Professional Medical Negligence in Nigeria' <https://nigerianlawguru.com/wp-content/uploads/2024/11/PROFESSIONAL-MEDICAL-NEGLIGENCE-IN-NIGERIA.pdf> accessed 24 July 2025; Dayo Adu, Esther Randle and Stephanie Modilim, 'The concept of medical negligence in Nigeria' (2022) Mondaq <www.mondaq.com/nigeria/professional-negligence/1220770/the-concept-of-medical-negligence-in-nigeria> 24 July 2025; Erik Encarnacion 'Two Standards of Repair: Restoration and Resilience' (2021) 2 Oxford Studies in Private Law Theory, U of Texas Law, Public Law Research Paper 1.

process of litigation alone can have a significant impact on their psychological and emotional well-being. In cases where judgment has been prolonged, parties usually experience re-traumatization, and they risk mental stress and psychological consequences. This is caused by patients and physicians relieving the event that caused the damage in the first place.

Medical negligence research in a global context has shown that patients and physicians are unsatisfied with the tort system. For example, Tumelty found that 'plaintiffs find the process of medical negligence litigation to be upsetting and distressing, and the research uncovered that the impact of litigation can manifest itself in a variety of ways, including the experience of pain, anger, disappointment and anxiety.'[181] Further, Tumelty also confirmed that 'consistent with international literature, the findings of this research indicate that medical negligence litigation can have a profound and long-lasting impact on medical practitioners.'[182]

Although most countries still operate upon the tort system in medical negligence disputes, there has also been the implementation of alternative models such as mediation, case management, and pre-action protocols have also been used as a means by which both temporal and financial concerns can be addressed. Thus, this research argues for the adaptation of a collaborative and relational approach based upon restorative approach principles. This process should be integrated into the current Nigerian system whereby patients, medical practitioners and others affected by the harm caused are enabled to

[181] Tumelty (n 153).

[182] Ibid.

participate actively in the justice process. This will offer patients and their families, physicians, and healthcare providers an opportunity to talk about their experience and to make good the harm done.

2.9 Implementation of Existing Alternative Models of Redress for Patients Who Have Experienced Medical Negligence in An International Context.

Alternative redress models have emerged around the world because of policy initiatives designed to address the inadequacies and shortcomings of the adversarial, expensive and slow tort system. For instance, mediation has been employed as an alternative to the tort system across various institutions to resolve disputes amicably and to serve as a means through which aggrieved parties can communicate to agree on a settlement that benefits patients and physicians. A case point is the United Kingdom, where the National Health Service Litigation Authority (NHSLA) has been encouraging its representative lawyers to consider and offer mediation in appropriate cases since 2000.[183] Similarly, Lai and Lee noted that a trained mediator typically facilitates the meeting to reach a mutually beneficial agreement during mediation. Further, they highlight the significance of mediation as an alternative for healthcare disputes and emphasise that maintaining confidentiality and a collaborative attitude between parties are vital principles that underpin facilitative mediation, making this approach particularly apt for resolving healthcare-related

[183] WH Danny Lee and BS Paul Lai, 'The practice of mediation to resolve clinical, bioethical, and medical malpractice disputes' (2015) 21(6) Hong Kong Medical Journal 560, 562.

disputes.[184] In their advocacy for mediation, they state that 'unlike litigation, non-monetary issues such as explanations, apologies, or even future strategies to enhance patient safety can be discussed during mediation.'[185]

Similarly, globally,, arbitration has also been an important part of the tort system reform in settling disputes amongst aggrieved parties. This supports Staszak's assertion that 'proposals to utilise arbitration instead of malpractice tort litigation have proliferated in recent decades alongside debates over healthcare reform.'[186] However, it has been observed that arbitration is less expensive than the tort system, less time-consuming, and helps alleviate the burden of cases on court dockets. While arbitration has been adopted more extensively in other sectors, particularly the private sector, the use of arbitration and other administrative alternatives remains relatively recent and not yet commonplace in medical malpractice. In arbitration, parties agree to submit a dispute, either before or after it arises, to one or more neutral third parties for binding resolution.

Despite provisions in Nigerian law that allow both arbitration and mediation in medical malpractice claims, these models have not been implemented. This is primarily because Nigeria still relies heavily on the tort system to settle medical malpractice claims and because the law is new and does not have built-in systems. For example, arbitration, essentially the alternative model to litigation in Nigeria, can be costly, though binding, yet

[184] Ibid.

[185] Ibid.

[186] Sarah Staszack, 'In the Shadow of Litigation: Arbitration and Medical Malpractice Reform' (2019) 44 (2) Journal of Health Politics, Policy and Law 267, 271.

it has not been implemented to resolve medical negligence disputes. This has resulted in a significant lack of research on alternative models within the Nigerian healthcare system, making it difficult to determine the satisfaction levels of both patients and medical practitioners with the process. The effectiveness of arbitration in dispute settlement is uncontested; as Sohn noted, 'arbiters do boast 100% avoidance of litigation, making arbitration very appealing to malpractice insurers and hospital systems, as even a successful defence can cost close to $100,000.'[187] However, the practical implementation in Nigeria and in medical negligence disputes is unassured.

While it should be noted that mediation, as an alternative dispute resolution model, is provided within the law to settle claims of medical negligence under the National Health Insurance Authority Act 2022, especially where conciliation fails, there is no procedural enforcement for mediation as an alternative. The extant legislation, the Arbitration and Mediation Act 2023 (AMA), further reinforces its non-binding effect. Moreover, while this offers a pathway for utilising an alternative to the current tort system for redressing patients, mediation remains voluntary. Its essence lies in designing processes to achieve consensual settlements outside the courtroom in a non-adversarial environment. Nevertheless, this does not undermine the effectiveness of mediation, as Sohn argues that 'mediation has had excellent success when implemented, both in terms of cost containment and satisfaction for both parties.'[188]

Considering the complexity of the existing alternative redress mechanisms in Nigeria, as

[187] Sohn (n 7).

[188] Ibid.

it relates to medical negligence and the settlement of medical negligence claims primarily through the tort system, there is a need to learn from evidence-based international initiatives that are proven to provide redress to patients who experience medical negligence. It is suggested that there is a need to adapt and integrate alternatives to the tort system in the Nigerian healthcare system based upon a collaborative and relational approach which involves meetings between patients and other stakeholders in a safe setting when harm occurs, which will seek to meet the needs of both patients and physicians. This should be the goal of a legal framework for redressing patients who have experienced harm in Nigeria and similar jurisdictions.

This framework is highly beneficial as it aims at encouraging the responsibility of medical practitioners and the safety of patients by ensuring that medical practitioners acknowledge harm when committed and disclose the implications and risks involved in treatment offered to patients to address the initial harm (damage) committed and prevent compound harm. This framework has the potential to shift the current tort system from a culture of blame to a culture of collaboration embedded in alternative mechanisms to provide healing, compensation, and reconciliation amongst affected parties. Further, it is believed that this can be achieved through listening to and understanding the experiences of patients and medical practitioners involved in incidents in a safe setting outside the courtroom and reaching an agreement on better strategies to prevent future harm.

2.10 Conclusion

This chapter analysed several key inadequacies of the tort system and statutory provisions

in Nigeria regarding medical negligence. It also delineated issues that apply to the traditional tort system adopted in Nigeria and considered whether the tort system can be reformed to improve patient safety and medical practitioners' responsibility.

Further, theoretical and empirical literature was used to illustrate the problems/ challenges faced by patients and healthcare providers within the healthcare setting, inter alia, how the existing system fails to repair the harm that patients and medical practitioners experience and how the system further compounds this harm by neglecting their needs and concerns individually and collectively. It explored the current system of tort, professional negligence, the medical duty of care, and the breach of medical duty, all instrumental concerns that contextualize medical negligence in Nigeria. It was shown that this current system of tort law and medical negligence creates resistance to change within the healthcare setting, which presents difficulty when attempting to address the safety of patients and the responsibility of healthcare providers. Despite the complexity of healthcare settings, their individual and non-relational nature, punitive and blame culture, and the adversarial process altogether, it is evident that policymakers retain their ability to respond to patient harm ineffectively and are reluctant to drive towards a culture of change that is based on communication and a better way of understanding between patients and healthcare providers.

Conversely, it examined the statutory provisions that patients can rely on when claiming negligence and the inadequacy of these provisions regarding enforceability due to substantive and procedural barriers. While there has been a commendable effort to establish some alternative provisions for tort, the procedural bottleneck remains a

significant obstacle.

Further, this chapter argues that the values and principles of restorative justice should be integrated into the Nigerian healthcare system by establishing a no-fault system. This should be the goal of a legal framework designed to redress patients who experience medical negligence within the Nigerian healthcare system.

Therefore, an alternative to the tort system, based on a collaborative and relational approach that involves meetings between patients, physicians, and other stakeholders in a safe setting when harm occurs, is suggested to be adapted or integrated. This approach would aim to meet the needs of both patients and physicians. The goal of a legal framework should be to provide redress for patients who have experienced medical harm in Nigeria and similar jurisdictions.

Each of the arguments highlighted in this chapter can influence how the Nigerian healthcare system addresses patient harm; they can also shape effective methods for ensuring dignity and respect for patients who experience harm by means of an apology, admission of responsibility, and actions to meet their needs. This is significant because the healthcare environment in Nigeria tends to withhold information, allowing physicians and healthcare providers to retain control and operate according to personal and organisational hierarchies. In this regard, communication and information exchange between physicians and patients can prevent medical negligence and reinforce the idea that patients have the right to lodge complaints, necessitating support systems for regularly reporting patient safety incidents. The following chapter examines the feasibility of the restorative approach

as a solution to the complexities of medical negligence within the Nigerian healthcare system.

CHAPTER THREE

RESTORATIVE JUSTICE VIS-À-VIS THE ALTERNATIVE MODELS TO THE TORT SYSTEM IN THE HEALTHCARE SETTING.

3.1 Introduction

The ultimate purpose of the law is justice, but this concept remains debatable.[189] Albeit, justice fundamentally supports any successful legal system, ensuring fairness, accountability, equity, and the protection of rights entrenched in legislation. As a concept, it is better described than defined; however, such description presents a complex and multifaceted meaning, as it may mean something different to the parties involved in the same dispute. However, it remains the fulcrum on which the law operates. As aforementioned, justice may represent an entirely different meaning for person A compared to person B within the same conflict, dispute, or context. Adopting the metaphor from the Indian folklore of the six blind men and the elephant, justice is represented by an elephant defined by blind men using their sense of touch. The metaphor is restated below:

> There were once six blind men who had heard of the animal called the elephant but did not know what one was like. To satisfy their curiosity, they decided one day to use their sense of touch to determine the creature's appearance. Matters became confusing, however, when each man touched a different part of the elephant and became convinced that he alone understood its true nature. "The elephant is very like a snake!" proclaimed the man who had touched its trunk. The fellow who had

[189] Otfried Höffe, *Aristotle's "Nicomachean ethics"* (Leiden, Brill 2010).

> touched its side, however, declared the elephant to be "nothing but a wall," whereas the man who touched the creature's tusk claimed that the elephant was "like a spear," and so on. It is no wonder, then, that the six men could not agree on the true appearance of the elephant.[190]

Consequently, the pursuit of justice has been in different forms, shapes, and modes throughout history influencing legal, political, religious and economic views. As a result, its importance cannot be overlooked in any dispute, including medical negligence disputes. Over the course of legal evolution, many systems and scholars have attempted to conceptualise justice as it intersects ethics and reason. The term 'Justice' transverses all spheres of legal enquiry. While it was debated in the past by notable scholars, it is still being discussed today by leading academics and will continuously be debated if human existence remains. Leading scholars and academics have progressively attempted to unearth the dynamics of justice. For example, Aristotle considers justice in his work 'Nicomachean Ethics.'[191] Similarly, John Rawls, heralded as one of the contemporary fathers of justice, also considers the theme of justice in his book 'Theory of Justice,'[192] which has encouraged the discourse of justice in various forms, sectors, and shapes. Incorporating some of Rawls's ideals, Daniels looks at justice from the relational perspective of the distribution of health.[193] Höffe also notes that justice could be a moral

[190] Pierre-Marc Daigneault, 'The Blind Men and the Elephant: A Metaphor to Illuminate the Role of Researchers and Reviewers in Social Science' (2013) 8(2) Methodological innovations 82.

[191] Höffe (n 189).

[192] John Rawls, *A Theory of Justice* (The Belknap Press of Harvard University Press 1999)

[193] Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press, 2008).

obligation that people owe to one another.[194] These efforts are commendable, but there remain many gaps to be filled in whether it has lived to its purpose and if there is an established nexus between justice and medical law.

Premised on the afore discussed, different forms of justice have emerged, such as distributive justice, corrective justice, retributive justice, adversarial justice and restorative justice, among others.[195] However, this chapter focuses on how restorative justice and adversarial justice through the tort system have been used in settling disputes in healthcare.

Traditionally, an adversarial (tort) system has been the primary and most popular mechanism for resolving medical negligence disputes and prioritising fault, liability, and compensation. Thus, the tort system's emotional, physical, psychological, and social deficiencies remain, and there is a gap in delivering its justice quota. In response to these gaps, restorative justice has emerged as a progressive, holistic, and integrated alternative to the conventional tort system. It offers a patient-centred approach that emphasises healing, accountability, and systemic improvements to meet patients' justice quests.

Furthermore, and considering the complexities in healthcare, both justice and medical law intersect within the perspective of patients' rights and the corresponding obligations of medical practitioners. It is essential to understand how restorative justice links patient

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[194] Otfried Höffe and Joost den Haan, *John Rawls, A theory of justice* (Leiden, Boston Brill 2013).

[195] Robert Nozick and Richard A Epstein. 'Distributive Justice' In Modern Understanding of Liberty and Property (1st ed, Routledge, 2000); Ernest J Weinrib, 'Corrective Justice in a Nutshell' (2002) 54(4) The University of Toronto Law Journal 349; Dragica Vujadinovic, 'Ronald Dworkin- Theory of justice' (2008) 8 (2) European Scientific Journal 1; Guillermina Jasso, Kjell Y Törnblom T, Clara Sabbagh and Manfred Schmitt, 'Distributive Justice' In *Handbook of Social Justice Theory and Research* (Springer New York, 2016); John Gardner, 'Distributive justice and regenerative medicine' (2017) 12 (7) Regenerative Medicine 865.

safety and trust with the vulnerability of medical practitioners, even in cases of medical negligence. Therefore, this chapter extensively examines restorative justice and its implementation in healthcare systems, especially when addressing medical negligence disputes. It presents restorative justice as a paradigm shift from the more conventional adversarial tort system to a non-punitive, communal approach to dispute resolution with the aim of enhancing the relationships of all stakeholders in a win-win approach.

Additionally, the origin of restorative justice has been traced to different starting points. Some scholars argue that it emerged from indigenous justice practices, while others have argued that it is a response to the retributive nature of the traditional adversarial system of torts. With this in mind, this chapter examines the history of restorative justice and its emergence and application in healthcare.

In testing the efficiency of the restorative justice principles as a whole and in healthcare, this chapter examines the gold-standard jurisdictions of restorative justice. For example, this chapter extensively considers how New Zealand and the United States have used restorative justice in operation and administration to replace and resolve medical malpractice cases or to operate side by side with the torts system. It further evaluates their approaches and comparatively examines and outlines significant advantages of restorative justice over the tort system. By investigating these systems, Chapter Three peruses the successes of these restorative models to the torts system, including their integral relevance in Nigeria's healthcare system to guarantee patient safety and compensation to patients who have experienced medical negligence.

While this chapter underscores the fallibility of the restorative justice system, it duly describes how such a system has trumped the torts system regarding the resolution of medical negligence disputes. The overall goal herein is to advance patient safety, increase medical practitioners' accountability, reduce medical negligence as practicably as possible and restore patients' trust in the healthcare system.

3.2 What Is Restorative Justice?

Restorative justice (RJ) emerged from a philosophy that focuses on 'how to improve and repair relationships between people and communities; the intention is to build healthy communities, encourage social capital, repair harm, and restore relationships.'[196] Understanding restorative justice before delving into its definitive function in healthcare settings is pertinent.

Restorative justice in its modern form emerged within the criminal justice system, emphasising the need to repair harm caused by criminal behaviour and not necessarily focusing on punishing the offender alone. Restorative justice is defined as a 'victim-centred response to crime that allows the victim, the offender, their families, and community representatives to address the harm caused by the crime.'[197] Although restorative justice is disputed as an originally Indigenous justice system (as discussed later in this chapter), its character employs non-state forms of sanctions. Still, it prioritises the healing of the person who has been harmed, typically caused by criminal

[196] Allison Leigh Kooijman, 'Healing After Healthcare Harm: The Potential of a Restorative Justice Approach' (Master's Thesis, University of British Columbia 2021).

[197] Lego Karjoko et al, 'The Urgency of Restorative Justice Medical Dispute Resolution in Indonesia' (2021) 16 (2) Jurnal Hukum dan Pranata Sosial 362, 366.

conduct/omissions, rather than merely punishing the offender.

The restorative justice approach emphasises repairing harm or wrongdoings by restoring relationships between the stakeholders involved, that is, offenders, victims, and the community. It is an attempt to ensure a win-win situation for all parties involved, whether patients, medical practitioners or families of patients who have suffered harm/ medical negligence. Further, restorative justice has been defined as an approach that seeks to replace hurt/harm with healing, especially bearing in mind that the perpetrators who commit the hurt/harm are victims of the incident themselves.[198]

The prioritisation of accountability, healing, and reconciliation over punishment remains the central atom of Restorative Justice. While it seeks to understand harm, it focuses on addressing the underlying causes of harm to prevent possible future wrongs. This is because patients are interested in knowing the facts and extent of injury they sustain when receiving medical care. Thus, the restorative approach guarantees the desired transparency where there is no forced disclosure, or publicity drives knowledge about errors.[199] Establishing this transparency is necessary to facilitate a healthy patient-physician relationship that fosters trust.

The concept of restorative justice, as advanced by its proponents, is that it provides a structured environment in which offenders and victims can dialogue on their injuries and

[198] Kaur Mannat et. al, 'Restorative Just Culture: A Study of the Practical and Economic Effects of Implementing Restorative Justice in an NHS Trust' (2019) 273 MATEC Web of Conferences 1 <www.matec-conferences.org/articles/matecconf/pdf/2019/22/matecconf_icsc_eswc2018_01007.pdf> accessed 12 December 2024.

[199] David M Studdert and Troyen A Brennan, 'No-Fault Compensation for Medical Injuries, The Prospect for Error Prevention' (2001) 286 (2) JAMA 217 <https://law.stanford.edu/index.php?webauth-document=publication/441277/doc/slspublic/JLM00050.pdf> accessed 22 September 2023.

hurts. Allowing offenders to acknowledge and explain the reasoning for their harmful acts, apologise and make restitution to the victim, who could forgive and feel safe again. It is expected that family members or community representatives will be present during this dialogue; the justification is to ensure public accountability, an inquiry into the root cause of the criminal or wrongful conduct, and to birth creative solutions to their existing problems.[200] Thus, healing is key to the principles of restorative justice at an individual and communal level.

To this effect, Ness and Strong state that 'offenders and their families to make amends to victims and their families – not simply to ensure that injured persons received compensation but also to restore community peace.'[201] Wachtel, the founder of the International Institute for Restorative Practices, defines Restorative practices as 'a social science that studies how to build social capital and achieve social discipline through participatory learning and decision-making.'[202] He noted that restorative practices help reduce crime, violence, and bullying, improve human behaviour, strengthen civil society, provide effective leadership, restore relationships, and repair harm.[203] Also, Kerry Clamp defines restorative justice as the broad philosophy that argues that those most affected by harm and conflicts should be involved in articulating the causes and/or consequences of that harm and/or conflict and empowered to make decisions about how to respond to and/or

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[200] Carrie Menkel-Meadow, 'Restorative Justice: What Is it and Does It Work?' (2007) 3 (1) Annual Review of Law and Social Science 16.

[201] Daniel W Van Ness and Karen Heetderks Strong, *Restoring Justice* (Cincinnati, 4th ed, Anderson 1997) 8.

[202] Ted Wachtel, 'Defining Restorative Justice' (2016), IIRP Graduate School, p. 1, <www.nassauboces.org/cms/lib/NY01928409/Centricity/Domain/1699/Defining%20Restorative.pdf> accessed 10 May 2024.

[203] Ibid.

resolve it.[204]

A restorative approach rests on the perspective of 'being' - a communitarian perspective of interconnectedness and the relational philosophy that we are connected. When harm has been committed in a healthcare setting, there is a breakdown of that relationship between patients and healthcare providers. This community and peacebuilding approach is focused on healing, where individual parties affected by patient safety come together to talk about their experiences through storytelling in the form of circles, facilitated meetings or conferences to prevent compounded harm and heal from initial harm. Armour emphasises this point by noting that the 'ultimate aim of restorative justice is one of healing,'[205] which aims to mend the 'broken relationship between three players: the offender, the victim and the community.'[206] Restorative justice is to promote and prioritise non-adversarial dispute resolution, such that even in medical negligence disputes, for example, it allows the injured patient and the medical practitioner to engage constructively and promote accountability.

Over the years, many arguments, myths, and complexities have surrounded the concept of restorative justice. Some authors have argued that it is not a type of justice, others argued that it is a type of justice, while some stated that it is merely a justice mechanism.[207] Even more, some have indicated that it is a response to retributive justice, and others have argued that it works in parallel with retributive justice. According to Kathleen, some restorative

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[204] Online Webinar, Oxford Prospects and Global Development Institute, 'Restoring series: legal, political, social and economic perspectives on global cooperation.' (2021) www.oxford-prospects.org/re-building-trust-in-law-and-order-restorative-justice-and-policing-practice-in-diverse-contexts/ accessed 21 May 2024

[205] Marilyn Armour, 'Restorative justice: some facts and history' (2012) 27(1) Tikkun 25, 26.

[206] Ibid.

[207] Kathleen Daly, 'What is Restorative Justice? Fresh Answers to a Vexed Question' (2016) 11(1) Victims & Offenders 9.

justice advocates over the years have *gospeled* the myths about restorative justice being the opposite of retributive justice or restorative justice using Indigenous justice practices and was the dominant form of pre-modern justice or that restorative justice is a 'care' (or feminine) response to crime in comparison to 'justice' (or masculine) response or that restorative justice can be expected to produce major changes in people.[208] Despite varying opinions, the central theme of restorative justice is that it is a means to an end of justice, and it is an end still – justice – through repair and restoration.

Overall, restorative justice is fast becoming a national and international social movement that aims to redirect society's response to crime and similar vices.[209]

3.3 History of Restorative Justice

The exact history of restorative justice is contested, as the historical lines have remained blurred in tracing the actual historical development of the term 'restorative justice.'[210] There are differing accounts of the origin of restorative justice. Some scholars assert that it has its roots in indigenous justice systems before the emergence of the traditional adversarial system; others have argued that it is a modern development used as a response to the flaws of the traditional adversarial system. For example, Braithwaite noted that restorative justice first emerged in criminal law, with its foundations in Arab, Greek, and Roman civilizations.[211] He referred to restorative justice as the dominant model of criminal

[208] Kathleen Daly, 'Restorative justice: the real story' (2002) 4 (1) Punishment & Society 55.

[209] Armour (n 205).

[210] Christian BN Gade, 'Restorative justice and the South African truth and reconciliation process' (2013) 32 (1) S Afr JPhilos 10, 28.

[211] J Braithwaite, 'Restorative justice' In MH Tonry (ed) *The handbook of crime and punishment* (Oxford University Press 1998).

justice throughout human history. Similarly, Grazia noted that restorative justice was 'born out of an unprecedented crisis within the criminal justice.'[212] Conversely, scholars like Weitekamp have noted that restorative justice is a pre-existing cursor for the criminal justice system deviating from the customary forms of dispute settlement in pre- historic times and dating back to the origin of the society.[213] In all, adopting the words of Kathleen Daly, 'there are many stories and no real one' on restorative justice.[214] Whilst the 'when'- exact origin is contested, there seems to be a settled platform on the 'how'- application methods have been settled.

Gade highlights that the 'historical research on the international use of the term 'restorative justice' has been limited.'[215] He noted that restorative justice as a term has been wrongly assumed by scholars to have been coined in the second half of the 20th century, especially as the term had previously appeared in texts as early as the 13th century. Nonetheless, the use of restorative justice in modern times is increasingly expanding in its form and use through different sectors. It is expedient to diverse into the history of restorative justice.[216]

Some scholars have argued that the term restorative justice was coined in criminal law in the 1970s others have argued that it was in operation before the 1970s. For example, Carrie

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[212] Mannozzi Grazia, 'Towards a "humanism of justice" through Restorative Justice: A Dialogue with History' Restorative Justice (Hart Publishing, Oxford, England 2017).

[213] GM Weitekamp, 'The history of restorative justice' in G Bazemore & L Walgrave (eds) *Restorative Juvenile Justice: Repairing the Harm of Youth Crime* (New York, 1999) 75, 82 cited in R Koen, 'Prolegomenon to a materialist history of restorative justice' (2012) 18 (2) Fundamania 77.

[214] Kathleen Daly, 'Restorative justice: The real story' (2002) 4 (1) Punishment & Society, Thousand Oaks, CA: Sage 55.

[215] Gade (n 210)

[216] Menkel-Meadow (n 200).

noted that the modern form of restorative justice movement began as a social practice 'in the 1970s as a response to what was considered to be an overly harsh criminal justice system that neither effectively deterred crime nor successfully rehabilitated offenders.' She argued that this movement was championed by 'social workers, progressive criminal treatment professionals (including police officers and prison reformers), some lawyers and judges, psychologists, and community and peace activists.'[217] Similarly, Marilyn Armour noted that restorative justice is an emerging field that sprung during the 1970s as 'alternative approaches to the court process'[218] whose values, principles, and practices evolved from Indigenous cultures.[219]

Ness and Strong asserted that to the best of their knowledge, 'the first use of the term 'restorative justice' in the context of criminal law was by Albert Eglash in several articles in which he suggested that there are three types of criminal justice: (1) retributive justice, based on punishment; (2) distributive justice, based on therapeutic treatment of offenders; and (3) restorative justice, based on restitution.'[220] Eglash has been accorded the title of one of the founding fathers of restorative justice with the likes of Howard Zehr.[221] Conversely, Carrie, in her paper, argued that restorative justice was practised first and later theorised by John Braithwaite, who is one of the acclaimed modern fathers of restorative

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[217] Ibid.

[218] Armour (n 205).

[219] Ibid.

[220] Ness and Strong (n 201) 22.

[221] Kathleen Daly, 'The Punishment Debate in Restorative Justice' In Jonathan Simon and Richard Sparks (eds), I The Handbook of Punishment and society (London, Sage Publications 2012).

justice.[222]

According to Christopher Marshall, a pioneer scholar on the integration of biblical studies and restorative justice,[223] he noted that the term was first coined in the 1970s to 'describe a way of responding to crime that focuses primarily on repairing damage caused by the criminal act and restoring insofar as possible, the dignity and wellbeing of all those involved.'[224] Contesting these assertions, Gade, in discussing the genealogy of the term restorative justice, noted that the term predates some of the existing records as noted by different scholars, as the term had appeared in six texts from the pre-1950 period, [225] as enumerated below:

1. The Christian Examiner and Church of Ireland Magazine from 1834, where it is explained that a certain Title Composition Act was 'deservedly hailed by all well-thinking men, as beneficial to the clergy, and to the people, as a great act of restorative justice' (Members of the Church of Ireland 1834: 2).

2. The Signs of the Times from 1848. In this book, Lebbeus Armstrong tells a story about two witnesses who had been unjustly Imprisoned for committing perjury and states that 'their release would be an act of restorative justice' (Armstrong 1848: 275).

3. John Stow's Thoughts on a Continuation of the Book of Common Prayer used in the Church of England from 1856. As a comment to Luke 19:8, where Zacchaeus tells

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[222] Menkel-Meadow (n 200).

[223] Restorative Church 'Christopher Marshall C'<https://restorativechurch.org/welcome-to-restorative-church-2/restorative-theology/christopher-marshall/> 25 May 2024.

[224] Christopher Marshall, 'Justice, restorative' In Joel B Green (ed) Dictionary of Scripture and Ethics (Grand Rapids Baker Academic 2011).

[225] Gade (n 210).

Jesus of Nazareth that he will give half of his possessions to the poor and payback fourfold if he has cheated anyone of anything, John Show writes: 'What a lesson of liberality and of restorative justice is here afforded to All, who profess faith in CHRIST and the adoption of the Tenets of His Gospel!' (Stow 1856: 54).

4. Burton Abbot's A Woman's Story from 1863. In this book, Cecil decides to give Salome a considerable amount of money which she, apparently, had been entitled to since childhood. It is explained that 'Cecil represented the case merely as an act of restorative justice' (Abbots 1863: 338).

5. Floyd R. Mechem's article 'An Inquiry Concerning Justice' from 1916. This text contains an explicit definition of 'restorative justice' as 'justice administered by the judicial machinery which restores man to his proper rights' (Mechem 1916:361).

6. A speech by Manuel Fourcade from 1924, in which he addresses the problems of peace after World War I. He claims that in biblical times, the enthusiasm of the Psalmist exalted itself in [226]a vision of justice embracing peace and states that '[i]t is fitting to reaffirm our belief in these ideas of restorative justice' (Fourcade 1924:768).

Nonetheless Gade conceded that the exact context of the use of the term in the texts is unclear to him especially since the first text was used in a Christian context.[227] Despite Gade's converse opinion on the origin of the term 'restorative justice', he noted that the term became more popularised by Zehr in the 1900s, noting him to be one of the single most influential authors on restorative justice.[228] The term soon became an internationally

[226] Gade (n 210) 14.

[227] Ibid 29.

[228] Ibid 30.

used legal lingo adopted by the United Nations and the European Union in the 2000s.[229] Comparing the advocacy of Zehr and Eglash on the propagation of restorative justice, Gade noted that the latter referred to retributive justice as a punishment technique for crime and restorative justice is the technique for restitution. However, he regarded the former as developing a sharp contrast between restorative justice and retributive justice, noting Ibid. restitution as the more important part of restorative justice.[230] Further, Gade referred to his personal email exchanges with Zehr, noting that Zehr, often credited with developing restorative justice theory, acknowledged Eglash's early contributions in the 1970s.[231]

Conversely, some other schools of thought opine that restorative justice predates the traditional adversarial systems of dispute settlements. As noted by Considine, biblical justice and most indigenous justices were restorative, especially in pre-colonial New Zealand, Maori which has a fully integrated restorative justice system[232] Negating this assertion, Kathleen Daly noted that restorative justice being used in Indigenous justice practices and being regarded as the dominant form of pre-modern justice is a myth, despite admitting to having limited knowledge of the practices of justice systems throughout the history of humankind and her knowledge is confined mainly to the past three centuries and to the developments in the United States and several other countries.'[233] Backing her stance, she asserted that:

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[229] Ibid 28.

[230] Ibid 30.

[231] Ibid.

[232] Daly (n 208) 61.

[233] Ibid 62.

> If the first form of human justice was restorative justice, then advocates can claim a need to recover it from a history of 'takeover' by state-sponsored retributive justice. And, by identifying current indigenous practices as restorative justice, advocates can claim a need to recover these practices from a history of 'takeover' by white colonial powers that instituted retributive justice. Thus, the history of 234justice practices is rewritten by advocates not only to authorize restorative justice as the first human form of justice but also to argue that it is congenial with modern- day Indigenous…

She argued that those who advocated that restorative justice prevailed before the imposition of retributive justice is a myth and is 'linked to their desire to maintain a strong oppositional contrast between retributive and restorative justice' and merely a pointer into maintaining a sharp contrast between the 'good and bad justice.'[235]

Kathleen Daly has further asserted that some scholars have coined the origin of restorative justice as a feminine response to the masculinity of retributive justice, which she does not fully agree with. She noted that gender-linked association is not empirically justified and it is misleading to 'think that an alternative to men's forms of criminal law and justice practices could be found by adding women's voice or reconstituting the system along the lines of an ethic of care.'[236] Further, she asserted that an attempt to sell restorative justice to a wider audience, advocates have painted a dichotomous, oppositional picture of different justice forms, with restorative justice portrayed as trumping retributive justice as

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[234] Ibid.
[235] Ibid 63.
[236] Ibid 66.

the superior option.[237] This framing holds a certain appeal, as it presents two clear choices and signals which one is the 'right' side. Whilst Kathleen Daly attempted to strike the myths and tell the true story of restorative justice, she did not quite hedge her 'factual' representations on one side of the coin, pointing to the exact origin of restorative justice. Her conclusions stated that the existing claims on the precise history of restorative justice are not authoritative histories and should not be viewed as origin myths.

Irrespective of the different versions of its origin, it is uncontested that Restorative Justice has now become a development in criminological thinking.[238] Whilst many scholars have defined and undefined restorative justice, its philosophical, legal, theological, and anthropological origins are premised on the ideal model of 'doing justice.'[239]

3.4 Defining the Restorative Approach in the Healthcare Setting

Increasingly, society is in desperate need to adopt varying approaches to problems of resolving disputes in healthcare systems that provide a conducive atmosphere for patients, medical practitioners, and the community to be seen and heard and restore trust in the healthcare system. Restorative justice approaches are emerging to address harm/injury in healthcare to fill gaps that threaten patient safety in the healthcare system. As a result, several initiatives have emerged in some jurisdictions of the world to promote the ideology of restorative justice in addressing initial harm in healthcare and providing closure to patients who may have experienced harm/injury because of medical negligence by

[237] Ibid 72.

[238] Braithwaite (n 211).

[239] Grazia (n 212).

addressing compounded harm.[240]

RJ thrives in healthcare settings where the traditional adversarial systems (torts), usually prioritising compensation, often fails to address the emotional and relational aspects of harm suffered by parties. Braithwaite noted that the 'restorative approach provides a process where 'all stakeholders affected by an injustice have an opportunity to discuss how they have been affected by the injustice and to decide what should be done to repair the harm.'[241] The inherent risks posed by an undeveloped healthcare institution without a reliable and just process to repair the harm occurring from patient safety incidents and preventing compounded harm endangers the overall security of the healthcare system.[242] Therefore, restorative justice offers stakeholders in the healthcare systems the allowance for acknowledging the harm experiences, understanding the impact of the harm, and collaboratively forge ways to repair the harm, and possibly prevent a future re-occurrence.

Drawing on the work of Lewellyn et al.,[243] Kooijman summarises some essential principles of the restorative approach specifically for healthcare settings. She asserts that a restorative approach could mitigate risk and reduce or repair the harm experienced by patients and healthcare providers while also aiming to prevent further harm to injured

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[240] Koojiman (n 196) 8.

[241] J Braithwaite, *Crime, Shame and Reintegration* (New York, Cambridge University Press, 1989).

[242] World Health Organisation, 'Patient Safety' (11 September 2023) <www.who.int/news-room/fact-sheets/detail/patient-safety> accessed 29 December 2024.

[243] Jennifer J Llewellyn Robert Howse, 'Restorative Justice- A Conceptual Framework' (Prepared for the Law Commission of Canada, (1999) <https://dalspace.library.dal.ca/bitstream/handle/10222/10287/Howse_Llewellyn%20Research%20Restorative%20Justice%20Framework%20EN.pdf;sequence=> accessed 8 October 2022; J. Llewellyn, et. al, 'Report from the restorative justice process at the Dalhousie University Faculty of Dentistry' (2015) Report from the restorative justice process <https://digitalcommons.schulichlaw.dal.ca/scholarly_works/420/> accessed 8 October 2022.

patients and medical practitioners.[244]

There is global interest in the practice of RJ across different healthcare institutions in addressing specific harms associated with the safety of patients and the accountability of healthcare providers. While the emergence of a restorative approach in healthcare settings has become a standard shift from the blame culture of professional negligence to a relational and collective culture, evidence has shown that programs have the potential to provide the opportunity for personal and systemic learning that could improve patient safety.[245] This has led to the development of programs in New Zealand, the United States, and other parts of the world that aim to address healthcare harm, offer compensation, and avoid the adversarial legal process.

For example, in evaluating a restorative approach for addressing harm from surgical mesh in New Zealand, the studies found that 'a combination of proactive and reactive restorative approaches can assist in meeting the substantive, psychological and procedural needs of many participants.'[246] Similarly, Kooijman[247] noted that communication resolution programs in the United States are intended to 'disclose unanticipated care outcomes to affected patients, and proactively seek for resolution.'[248] The restorative approach used in the surgical mesh project in New Zealand employed circles that facilitated meetings

[244] Kooijman (n 196) 11.

[245] Joanna Wailing, Jillian Wilkson and Chris Marshall, 'Healing after harm: An evaluation of a restorative approach for addressing harm from surgical mesh. Kia ora te tangata: He arotakenga i te whakahaumanu' (A report for the Ministry of Health) (2020) Wellington, New Zealand: The Diana Unwin Chair in Restorative Justice, Victoria University of Wellington. <www.wgtn.ac.nz/restorative-justice/research/health/restorative-practice-and-surgical-mesh/healing-after-harm-evaluation-report-moh-pdf> accessed 26 September 2022.

[246] Ibid 23.

[247] Ibid.

[248] Kooijman (n 196) 33.

between individuals, and the practice encouraged storytelling, empathy, and accountability. It is necessary to suggest that there needs to be a shift from the adversarial process to a non-adversarial process within the healthcare setting where solutions are sought through collaboration and consensus.[249]

This section conducts a literature review of programs implemented in other jurisdictions in the form of circles, facilitated meetings, and other restorative approaches, particularly in New Zealand and the United States. It further contributes to the literature on the practicability of a restorative approach in the Nigerian setting. It contributes knowledge to the body of literature on how a restorative approach can address patients' safety, ensure medical practitioners' accountability, and shift the medical liability system from a blame culture towards a restorative culture.

While the traditional punitive justice and administrative framework are concerned with a blame culture, a restorative approach seeks to meet the needs of those involved in the experience of harm. The growing number of harms experienced by patients, healthcare providers and their families in healthcare systems across the globe prompted healthcare practitioners and policymakers to rethink better ways to address the problematic nature of the existing medical liability system. As a result, the restorative approach in the healthcare setting is now being widely used as facilitated meetings between patients, physicians, and their loved ones, whereby parties collaborate and express their true feelings about what happened, and they all agree to do something to fix the harm. While restorative practices

[249] Ibid 7.

shift the system from a blame culture to a relational and collaborative restorative culture, it is argued that this framework works better alongside or as integration into a no-fault medical liability system.

3.5 Restorative Justice in Healthcare – International Case Studies

In this section, I will discuss how restorative justice has been used in international contexts and how effective it has been, especially in addressing healthcare, using New Zealand and the United States.

The development of programs within healthcare settings underpinning restorative approach principles has gained pace in recent years, especially since negligence claims continue to increase in developed countries, resulting in an alarming number of incidents affecting patient safety. While this has raised concerns within healthcare institutions and alternative models have been developed, evidence shows that the restorative approach continues to gain minimal attention within the field. Although theoretical and practical approaches have been in the literature, New Zealand and the United States appear to have executed a formalised large-scale restorative approach to responding to healthcare harm directly.

To ascertain the effectiveness and potential of these programs, diverse health institutions globally will need to adopt restorative approach principles and values within their institutional and regulatory frameworks. This will contribute to both theoretical and practical understanding of the restorative approach in the healthcare setting and will inform global policy, standards, and protocols on the implementation of the restorative approach.

This section will discuss major programs that have been implemented both in the United States and New Zealand, and the programs selected from both countries have contributed remarkably to the literature on the benefits of a restorative approach to patients and healthcare providers who experience harm.

3.5.1 New Zealand

New Zealand is a forerunner in implementing the principles of restorative justice procedures in its criminal justice system.[250] However, these principles have now been expanded to the civil justice system. New Zealand has a combined integrated restorative justice principle into its no-fault medical liability system. For example, the Accident Compensation Corporation (ACC) facilitates restorative justice processes focusing on patients' grievances,[251] ensuring accountability and improving healthcare practices.[252] New Zealand has established a two-route system in their medical malpractice system, one that leads to monetary compensation and the other non-monetary forms of accountability. The monetary component of the New Zealand justice system is discussed in Chapter 4. Below is how restorative justice (non-monetary component) has been used in medical practice in New Zealand.

The restorative justice principles used in New Zealand were originally developed in the youth justice system before being used in healthcare disputes. The goal was to deal with

[250] Sarah Mikva Pfander, 'Evaluating New Zealand's Restorative Promise: The Impact of Legislative Design on the Practice of Restorative Justice' Kōtuitui: (2019) 15 (1) New Zealand Journal of Social Sciences Online 170 <www.tandfonline.com/doi/full/10.1080/1177083X.2019.1678492> accessed 23 September 2023.

[251] M Bismark et al., 'Accountability sought by patients following adverse events from medical care: the New Zealand experience' (2006) 175(8) Canadian Medical Association Journal 889.

[252] Kooijman (n 196) 19.

proceedings of offenders between the ages of fourteen and seventeen, as it aimed at strengthening the ability of families to hold their young members accountable and support their development in legally and socially productive ways.[253] Fred McElrea, a judge of the Auckland District Court, New Zealand, noted that a few years before the term restorative justice became popular in New Zealand, the Children, Young Persons and Their Families Act 1989 introduced the Family Group Conference.[254] He noted further that the distinctive elements of the restorative justice principles adopted in New Zealand's justice system helped the transfer of power from the government to the community, prompted a community response and guaranteed the involvement of stakeholders such as victims in making possible a healing process for both offender and victim.[255] In consolidating the efficacy of the positive progress restorative justice made in New Zealand, McElrea cited the High Court case of RE v Police (unreported, Christchurch Registry, AP 328/94, 2 March 1995, Williamson J), noting that the court referred to the Youth Court model as:

> a restorative justice system rather than a retributive or deterrent system. The new provisions were intended' to enable victims and the community, as well as young persons, to participate in a process which would help them and heal the damage caused by their offences. An essential part of this process is a negotiated community response at a family group conference. It is a system which operates in a vastly different way to that which Courts are required to use in dealing with adult

[253] Gabrielle M. Maxwell & Allison Morris, *Family, victims and Culture: Youth Justice in New Zealand* (the Social Policy Agency and the Institute of Criminology, Victoria University of Wellington 1993).

[254] Fred McElrea, Restorative justice- a New Zealand perspective' (Modernising Criminal Justice -New World Challenges conference, London, June 2002) <www.napierlibrary.co.nz/assets/Judge-McElrea/restorative-justice-nz-perspective.PDF> 6 December 2025.

[255] Ibid.

offenders.[256]

Consequently, restorative justice was applied in medical law as an avenue to improve the playing field. This approach aligned with New Zealand's commitment to human rights and social justice. It prompted the establishment of the Health and Disability Commission (HDC) in 1994 pursuant to the Health and Disability Commissioner Act 1994, charged with the role of promoting and protecting the rights of health and disability services consumers and facilitating the fair, simple, speedy and efficient resolution of complaints.[257] In addition to promoting patients' rights and responsibilities, the HDC acts as a gatekeeper for disciplinary proceedings in serious cases, ensuring that complaints are utilised to enhance the delivery of health services and that lessons learned are shared widely.

The HDC had the duty to investigate complaints from patients relating to medical care and sub-standard care; it also facilitated dispute resolution through restorative justice principles and enforced the Code of the Health and Disability Services Consumers Rights. This code sets ten rights, which include the right to be treated with respect, freedom from discrimination, coercion, harassment and exploitation, right to dignity and independence, services of an appropriate standard, right to effective communication, right to be fully informed and informed consent, to support, right to respect of teaching or research and the

[256] Ibid.

[257] Frank Frizelle, 'Review of the health and disability Commissioner Act and Code- your chance to have your say' (2024) 137 (1599) New Zealand Medical Journal <https://nzmj.org.nz/media/pages/journal/vol-137-no-1599/review-of-the-health-and-disability-commissioner-act-and-code-your-chance-to-have-your-say/258faae334-1721184750/1599-second-editorial.pdf> accessed 1 January 2025.

right to complain.[258]

As opined by Frizelle, this was aimed at driving accountability sought by patients who have been injured in the healthcare system. Under this regime, cases were dealt with timely where there was no need for a full investigation and it could be up to three years when the complaints required detailed investigation.[259] These investigations have led to significant progress in the provision of healthcare services in New Zealand, such as establishing what is expected of healthcare providers in delivering optimum care and giving patients a voice in healthcare provision, among others.[260]

In New Zealand, the ACC is no longer required to report individual health practitioners to professional disciplinary bodies in the event of a medical misadventure. This promotes patient safety, trust between practitioners and patients, and a culture of open disclosure and learning from medical injury cases. With open disclosure of medical errors, the ACC is required to report the data collected in the case of treatment injuries in circumstances where there is likely to be a risk of harm to the public to the authority responsible for patient safety.[261]

Notably, restorative justice in medical negligence cases is not compulsory in New Zealand. However, it is becoming more popular as a means of settling conflicts and guaranteeing that

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[258] Code of Health and Disability Services Consumer's Rights, <www.hdc.org.nz/your-rights/about-the-code/code-of-health-and-disability-services-consumers-rights/> accessed 1 January 2025.

[259] Frizelle (n 257).

[260] Ibid.

[261] Accident Compensation Act 2001, s. 284(2)

patients who have been injured in the medical care system receive compensation and can dialogue and seek closure. This emphasises communication between patients, medical staff, organisations, and parties to acknowledge the harm, provide an explanation for what transpired, and possibly offer an apology or make amends.[262]

3.5.1.1 Restorative Practices Used in Surgical Mesh in New Zealand

In 2019, the New Zealand Ministry of Health commissioned a restorative approach project to listen to the stories of those who have been affected by surgical mesh. Wailing et al. noted that the phases of the project included listening and understanding, planning and acting, reporting and evaluating.[263] This project implemented values and principles of a restorative approach, which brought together affected parties in a safe and secure setting through circles, facilitated meetings between individuals and restorative conversations.[264]

The aim of the restorative practices used in surgical mesh in New Zealand was to create a safe place and setting whereby parties can share their stories about what happened, repair the harm that has been done and do something to prevent it from further occurring. While the New Zealand surgical mesh restorative approach appears to be the most extensive practical application on a national scale, it should be noted that '585 mesh injured people and their families participated in the original project, 423 agreed to be contacted for research purposes, 215 responses were included in the analysis indicating a response rate

[262] Kooijman (n 196) 19.

[263] Wailing et al., (n 245).

[264] Ibid.

of 50.8 per cent.'[265] Participants of the mesh project indicated a positive response to the listening and understanding phase of the project, and it should be noted that key procedural adaptations included the responsibility of relevant stakeholders and the provision of emotional and psychological support post-meetings to patients and physicians.

Participants of the project also indicated the need for an apology from specific responsible parties, such as the ACC and the treating doctor. Such an apology is expected to be issued for initial and compounded harm. While the question has been posed in the New Zealand project on whether restorative approaches should be used in the health context, evidence shows that 'meetings between patients and physicians and others (sic) were seen potentially to provide the opportunity for personal and systemic learning that could improve safety culture and practice.'[266] This suggests that there is a potential for and a need to extend the reach of restorative approach beyond borders, which is important towards the humanization of healthcare systems across the globe but, importantly, essential towards the adaptation of relational, collaborative, communicative, culture as underpinning values and principles of healthcare systems globally.

Evidence from hearing and responding to the stories of survivors of surgical mesh in New Zealand indicates that 'over 600 consumers told their stories in Listening circles, individual conferences or the database, 140 registered for a listening circle.'[267] It is important to note that patients who participated in circles described the impact of surgical mesh on them.

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[265] Ibid.
[266] Ibid
[267] Wailing et al., (n 162)

They also described the traumatic and emotional impact and a loss of identity; some claim that the grief they continue to suffer from the loss of a loved one because of mesh is difficult to wipe away and that there has been unaccountability by responsible parties.

Also, many participants of the New Zealand project raised concerns about informed consent, stating they were unaware of the complications of mesh, which was not disclosed to them prior to the surgery. Many believed they would have never undergone the process if they knew the risk implications of mesh. While the use of a restorative approach created awareness about adverse events by providing proper disclosure and information to patients, healthcare professionals equally benefited by understanding the impact of the harm they have caused to patients. Although a restorative approach creates a relatively beneficial platform for both patients and physicians who have been impacted by harm, it also has the potential to ensure cooperation through better information sharing and providing psychosocial support to address individual physical, mental and social needs. A restorative approach will improve informed consent in a healthcare setting through proper advice on the risk involved in a patient's treatment and collaborative support from all responsible parties. This aligns with the notion that health workers need access to important information to help them make proper decisions, which will improve their ability to meet the safety needs of patients.

The evaluation of the restorative approach in the New Zealand surgical mesh project has shown that patients feel reluctant to complain about the harm they have suffered. Studies have shown that 'in the period 2014/25- 2018/19, the HDC recorded 45 complaints relating

to surgical mesh.'[268] Although this low number of reported cases reflects a lack of transparency and communication, patients' choices and opinions remain neglected, and their respect is not valued. The evaluation of the New Zealand project revealed that patients need to relate to the commitment for the better and transparent relationship between health providers and other stakeholders, while some patients also express the need for an apology or the accountability of those responsible for causing the harm.[269] While this appears to be a significant need of patients that healthcare institutions must aim to meet, there is also the need to ensure that organizations established to address patients' needs play an effective role in the area of advocacy through raising awareness about harms and incidents that affect parties within a complex health environment.

This research focuses on how the restorative approach can facilitate effective communication between patients and physicians and increase awareness about reporting harms patients suffer in healthcare. It urges policymakers and legislators in Nigeria (the focus of this research) and similar jurisdictions to learn from New Zealand restorative practice and experience and explore the transferability of the approach used in New Zealand into the Nigerian context to encourage patients to report incidents, provide collaboration and support between stakeholders, and put patients first.

3.5.2 United States

The United States, like other countries, face the similar challenge of a growing medical

[268] Wailing et al., (n 162).

[269] Ibid.

negligence portfolio threatening patient safety and trust in the healthcare system.[270] This has surged the number of medical negligence claims in court through the tort system, making it an adventure unsustainable to patients, medical practitioners and stakeholders involved in the administration of care.[271] For example, in the United States, many lawyers decline to represent prospective clients in medical negligence litigation if the damages sought are less than $250,000 leaving a significant gap in accessing justice.[272] In response to some of the deficiencies of the tort system, some States in the United States have also integrated restorative justice mechanisms into their justice system to resolve medical negligence disputes through various initiatives that are now discussed below.

3.5.2.1 Communication Resolution Programs (CRPs)

Information and accountability for patients who suffer harm within the healthcare setting have become a priority and a primary concern of health institutions globally. Patients now require and seek information on what has happened, why it has happened, and what needs to be done to repair the harm they have suffered. However, healthcare providers have experienced significant challenges in ensuring the safety of patients through proper disclosure. The responsibility of health professionals has been challenging to achieve due to extant legal frameworks focused on the blame culture.

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[270] B Sonny Bal, 'An Introduction to medical malpractice in the United States' (2009) 467 (2) Clinical Orthopaedics and related research 339.

[271] Eva Epker, ''Truly Unsustainable": The Effect of Medical Malpractice on Caregiving' (2024) <www.forbes.com/sites/evaepker/2024/07/18/truly-unsustainable-the-effect-of-medical-malpractice-on-caregiving/> accessed 29 December 2024.

[272] Ray Nickson and Alice Niekerk, 'Restorative Justice in healthcare settings: better outcomes for patients and medical professionals' (2024) 49 (2) Alternative Law Journal 82.

Communication Resolution Programs (CRPs) have emerged in certain jurisdictions to improve communication between patients and medical practitioners. They have become the best practice for addressing patient harm and preventing compounded harm.[273] CRPs create a platform for patients, physicians, their family members, and other important stakeholders to sit down and openly discuss the impact the harm has caused and to repair the damage done.

CRPs were developed in the United States, and 'its origins can be traced to Lexington, Kentucky Veteran Affairs Hospital and the University of Michigan Health System.'[274] As Boothman, Sarah, and Campbell noted, the University of Michigan Health System made a systemic change in how patients' injuries and medical malpractice cases were handled by adopting a proactive, principle-based approach and an 'open disclosure with offer model' built on a commitment to honesty and transparency.[275] This significantly reduced litigation costs and raised patient satisfaction, demonstrating the value of restorative justice in resolving medical negligence disputes. Therefore, Subsequent projects were sponsored by the Agency for Healthcare Research and Quality.[276]

Studies have shown that efforts began in the 1980s to improve the way healthcare providers respond to medical errors as disclosure about the adverse incident was a moral

[273] MM Mello et. al, 'Ensuring successful implementation of communication-and-resolution programmes' (2020) 9 BMJ Qual Saf 885, 895 <https://qualitysafety.bmj.com/content/qhc/29/11/895.full.pdf> accessed 10 October 2022.

[274] Ibid.

[275] RC Boothman, SJ Imhoff and DA Campbell Jnr, 'Nurturing a culture of patient safety and Achieving a lower malpractice risk through disclosure: Lessons Learned and future directions' (2012) 3 Front Health Serv Manage 13 <https://pubmed.ncbi.nlm.nih.gov/22432378/> accessed 1 January 2025.

[276] MM Mello et al. (n 273)

and professional responsibility.[277] While there has been increased implementation of programs on a national scale in the United States, Mello et al. asserted that there are distinctive factors associated with successful implementation and that, today more than 200 hospitals have commenced CRP implementation.[278] Two major examples of community resolution programs have been described in the literature in the United States: Community Apology and Resolution (CARe), and Community and Optimal Resolution (Candor).

3.5.2.2 Community Apology and Resolution (CARe) Program

CARe is a Communication Resolution Program that originated out of two Massachusetts hospital systems. Evidence has shown that 'the programs were implemented with high fidelity with positive results on key measures.'[279] It aims to enhance communication surrounding adverse events, improve patient safety, support clinicians in disclosing adverse events, reduce lawsuits and promote reconciliation by proactively meeting injured patients' needs.[280] The CARe programs are distinctive from other CRP programs based on their success, and evidence has shown that organizations that implemented CRP in the United States experienced certain difficulties and were unable to overcome certain barriers. However, findings of the CARe program demonstrate factors facilitating successful implementation. Mello et al. identified these factors to be 'support from top institutional

[277] Thomas H Gallagher et al., 'Can Communication -And-Resolution Programs Achieve Their Potential? Five Key Questions' (2018) 37(11) Health Affairs 1845 <www.healthaffairs.org/doi/10.1377/hlthaff.2018.0727> 22 September 2022.

[278] MM Mello et al. (n 273).

[279] Ibid 896.

[280] Ibid

leaders and risk managers, heavy investments in engaging physicians, active cultivation of a relationship with the insurer, use of formal decision protocols and structure, oversight and assistance from project managers, group implementation and small hospital size.'[281] The key elements of CARe are:

> formal protocol including decision criteria and pathways… Following an internal investigation, the hospital decides whether or not to refer the event to the liability insurer or self-insured claims unit… for possible compensation… Following the insurer review, a meeting is convened with the patient/family to discuss a resolution.[282]

3.5.2.3 Communication and Optimal Resolution (CANDOR)

It is also worth noting that CANDOR (called the Communication and Optimal Resolution), an implementation toolkit developed with funding from the Agency for Healthcare Research and Quality (AHRQ) to scale a restorative approach across the United States, has been used more. Kooijman notes that 'the CANDOR process is intended to improve patient safety through an empathetic, fair and just approach to medical errors and promote a culture of safety that focuses on caring for the patient, family and caregiver, and in-depth investigation and analysis; and resolution.'[283] CANDOR is a process that healthcare institutions and practitioners can use to respond quickly when patient harm occurs. CANDOR deals pertinently with the needs of patients, it pertains to the prevention of further harm, and it focuses on the improvement of patient safety. Fading noted that 'over

[281] Ibid

[282] Ibid 896.

[283] Kooijman (n 196) 7.

ten years of empirical data has evidenced that patient safety and quality of care improves when healthcare institutions are empathetic, fair and just in their approach to medical error.'[284] It should be known that evidence shows that CANDOR possesses an in-depth investigative analysis that aims to prevent medical liability and patient safety. Nonetheless, doctors have been pushing back against CANDOR, for example, the fear of doctors admitting to medical liability, thereby availing early compensation to patients. According to Fadling's notes, 'doctors and hospitals are pushing back against fear, believing that protecting patients from preventable harm is not the right thing to do.'[285]

The notion that early disclosure will result in settlement underpins the blame culture and is far from the perspective of a restorative approach. It is pertinently suggested that there is a need for a balanced approach within the healthcare setting focused on the inclusion and the commitment of multiple stakeholders, involving patients and healthcare providers sharing their stories about what happened and learning better ways to prevent it. This relational approach is essential in understanding the linkage between patient safety and medical liability to contribute to the dearth of literature on restorative approaches in healthcare settings.

3.5.2.4 Communication and Resolution Programs in General

It is noteworthy that there are many diverse forms of communication and resolution programs in the United States. Other forms of CRP have been employed in many states of

[284] Nancy Fadling, 'CANDOR – At the Heart of Patient Safety,' (2017) Spring edition, Journal of Health Care Finance 4 <www.healthaffairs.org/doi/10.1377/hlthaff.2018.0727> 22 September 2022.

[285] Ibid.

the United States, one of which is in the form of apologies pursuant to apology laws. Ho and Lui noted that the Apology Laws were enacted such that they render physician apologies inadmissible in court to encourage patient-physician communication and to overcome the physician's disinclination to apologise because apologies may be tantamount to inviting lawsuits.[286] Nonetheless, this has created a forum for greater openness in discussing medical errors, increased the trust of patients in the healthcare system, and potentially dissuaded lawsuits.

There has also been scepticism in the literature about whether CRP programs effectively meet the needs of patients and physicians or improve patient safety.[287] In addition, there is also a dearth of literature on the outcomes of programs other than the argument that communication and resolution practices reduce liability costs. Gallagher et al. discuss five critical questions in their article and purport that these questions will shape the future of Communication Resolution Programs.[288] The first question is how can greater adherence to core communication-and-resolution practices be encouraged, the second question is whether communication-and-resolution practices are evidence-based and linked to patient safety, the third question is what are the offers of compensation made in communication-and-resolution are fair to patients, the fourth question is on how communication-and-resolution programs can ensure alignment with participants needs and the fifth question is on how can state and federal policymakers best support communication-and-resolution

[286] Benjamin Ho and Elaine Liu, 'Does sorry work? The impact of Apology Laws on malpractice' (2011) 43 (2) Journal of Risk and Uncertainty 1 <www.uh.edu/~emliu/jru11/JRU_final.pdf> accessed 1 January 2025.

[287] MM Mello et al. (n 273).

[288] Thomas H Gallagher et al. (n 277).

programs going forward. Nonetheless, it has been concluded that 'organisations that implement CPR should strive for fidelity to the model and rigorously evaluate their performance with meaningful metrics.'[289] It is suggested that future research should focus on exploring the experiences of patients, healthcare providers, and their family members with Communication programs. This is in support of Moore et al. assertion that 'the Communication Resolution Program is young with much room to grow.'[290]

While it is believed that the origin of Communication Resolution Programs is related to the need to address patient safety, research suggests that the focus may have shifted now to liability outcomes. Gallagher et al. purported that 'origins in research documenting patient's belief that the response to medical injury should include openness, accountability and learning.'[291] They further noted that 'this reflects stakeholders' concerns that the approach would substantially increase medico-legal costs.'[292] Also, while evidence within the literature has pointed to a link between the safety of patients and evidence-based CRPs, evidence suggests the need for CRP programs to ensure interoperable transparency and a systemized safety culture focused on reporting incidents. Nonetheless, studies have shown that 'CRP implementation is correlated with improvement in at least one safety–measurement system: incident reporting.'[293] It should also be noted that the link between Communication and Resolution Programs is theoretical.[294] This correlates with the view

[289] MM Mello et al. (n 273).

[290] Jennifer Moore, Marie Bismark and Michelle M Mello, 'Patients' Experiences with Communication-and-Resolution Programs After Medical Injury' (2017) 177 (11) JAMA Internal Medicine 1595.

[291] MM Mello et al. (n 273).

[292] Ibid.

[293] Ibid.

[294] Ibid.

of this research for further research on the link between patient safety and an evidence-based restorative approach in a healthcare setting.

Overall, despite the development of different restorative justice regimes in the American healthcare system, there are still many fields to be filled in its full integration of a patient-centred approach. Further, it serves as a bedrock for development from which other jurisdictions can take cues in fostering truly transparent and accountable healthcare that prioritises patient needs and well-being over adversarial litigation.

3.6 Conclusions

Global efforts are being made to adopt restorative justice principles in healthcare. This is because of the dynamics it presents which not only cause just processes for patients and medical practitioners but also provide an opportunity to heal from harm for all parties and stakeholders involved.

Although the adoption of restorative justice has been met with pushback, especially with the existing retributive systems, which are primarily for punishment and a form of deterrence, the retributive system has not achieved much or at least succour to injured parties. RJ has benefits such as qualitative improvements for staff, a reduction in inappropriate suspensions and dismissals, an increase in the reporting of adverse events, and an increase in the number of staff who feel encouraged to speak, slowing down the upward trend in absence due to illness as well as improved staff retention. Additionally, Restorative justice principles have been acclaimed to provide economic benefits, such as a drastic reduction of costs associated with the suspension of medical practitioners, cost of

legal action, and agency cost for the backfill of staff absenteeism, amongst others.[295]

Restorative justice has become an effective mechanism for resolving medical negligence disputes in the United States. Through CRPs, mediation, and apology laws, healthcare institutions have been able to reduce malpractice claims, lower litigation costs, and improve patient satisfaction. Nigeria could benefit from adopting similar approaches to enhance medical accountability while maintaining trust within its healthcare system.

[295] Mannat (n 198).

CHAPTER FOUR

MITIGATING THE CHALLENGES OF THE TORT SYSTEM THROUGH A NO-FAULT APPROACH

4.1 Introduction

The practical and ethical benefits of the tort system in resolving medical negligence disputes from a patient-centred perspective have often been questioned. This scepticism stems from the initial and compounded harm that patients who have suffered medical negligence and their families endure in seeking justice and appropriate compensation through the rigours of the tort system. Thus, this chapter discusses the no-fault system in contrast to the tort system. While there are similarities between the two concepts, particularly regarding compensation for individuals who have experienced medical negligence, this chapter primarily focuses on the no-fault system.

The No-fault system is designed to ensure justice and guarantees of compensation for patients who suffer injuries due to medical negligence in the healthcare sector. In this system, the key requirement for justice is demonstrating injury rather than proving its negligent cause.

The No-Fault system emphasises healthcare providers' accountability and the operational frameworks of legal and insurance structures in addressing patient safety and compensation through a simplified, patient-centred approach. This chapter explores the necessity and advantages of the No-Fault System compared to the tort system. Some of these include timely compensation, efficiency, and effectiveness in fostering a culture of

openness within the healthcare setting.

Additionally, this chapter examines the history of the no-fault system and its developments. It highlights some commendable impacts of the no-fault system in administering justice, particularly in disputes related to healthcare. Furthermore, it assesses the application of the no-fault system in an international context within the healthcare setting. It also discusses how it has effectively improved patient safety and the quality of care in jurisdictions such as New Zealand, Sweden, Denmark, and the United States.

Furthermore, it discusses how a no-fault regime can enhance healthcare safety, promote transparency, and ensure fair compensation for harmed patients while reducing the challenges associated with traditional litigation by shifting the focus from individual blame to collective responsibility. This chapter acknowledges that there are obstacles to implementing such a system, including financial issues, establishing eligibility criteria, and ensuring accountability in the absence of traditional negligence claims, even those that may arise despite medical practitioners doing their best to salvage the situation. In addition to providing comparative perspectives from regions where no-fault procedures have been successfully adopted, this chapter will critically examine these challenges.

4.2 The Nature of No-Fault System

The no-fault system does not hinge on blame or individual healthcare provider's fault; rather, it enhances patients' safety and access to compensation for medical liability. This approach represents a paradigm shift through a thorough mechanism that does not predicate compensation on proof that medical practitioners failed to meet the expected

standard in their practice.[296]

The no-fault system is founded on the principle that injured parties can obtain compensation without needing to prove which individual or entity is responsible for the injury sustained. The aim is not to embark on a fault-finding expedition but to foster an ecosystem where trust between patients and medical practitioners is maintained. Adopting Carlson's analogy, a 'car crash is a car crash,' the key decision regarding recovery is whether the injury stemmed from the car crash itself, thereby eliminating the need for fault-finding.[297] It is an administrative, non-judicial process for individuals to seek compensation for alleged injuries, often hindered by emotionally excessive and exhausting litigation.[298]

Even when intervening circumstances, such as medical negligence, are present, the central issue remains whether the claimant suffered an injury. Baker highlighted evidence suggesting medical practitioners and claimants often leave the tort system dissatisfied.[299] Therefore, the no-fault system offers a win-win approach for patients and medical practitioners, allowing aggrieved patients to engage with the judicial system without fear or hesitation, yet with an expectation of accountability.

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[296] Studdert and Brennan (n 199).

[297] Rick J Carlson, 'A Conceptualization of a no-Fault Compensation System for medical Injuries.' (1973) 7 (3) Law & Society Review 329, 356.

[298] IFPMA, 'No-fault compensation systems and legislative liability protections white paper' (April 2023) www.ifpma.org/wp-content/uploads/2023/03/20232703_Joint_Pandemic_Vaccine_Liability_White_Paper_IFPMA.pdf#:~:text=No%2Dfault%20compensation%20is%20an%20approach%20based%20on,to%20prove%20that%20the%20vaccine%20is%20defective.&text=These%20NFC%20systems%20cover%20people%20in%20147,of%20national%2C%20regional%2C%20and%20global%20NFC%20systems.> accessed 1 January 2025.

[299] Barker (n 164).

The no-fault system adopts a compensation mechanism that aims to reduce the blame culture, eliminate the fault criterion, and offer a more rapid compensation to medically injured victims in a less adversarial manner.[300] The system is discussed as an advocate for pioneering justice in record time by not requiring claimants to demonstrate that they have suffered medical negligence within healthcare systems. However, what is required is to show injury, but the burden of proving causation is waived under a no-fault system. As a result, patient safety is guaranteed and trust rekindled trust in the healthcare system. Jones notes that 'the conceptual underpinning of a scheme of no-fault compensation rests on a theory of social responsibility for the victims of misfortune, namely those who suffer injury by accident.'[301]

The No-Fault system is an essential legal framework designed to compensate patients without the need to prove fault or demonstrate the negligence of the defaulting party. Ideally, this approach aims to address matters with urgency and efficiency. It promotes social solidarity that does not burden individuals, but the community, with the costs of accidents or their aftermaths.

Over the years, prominent voices have highlighted the significant relevance of the no-fault system. For example, Vincent explains that 'in a no-fault compensation system, an expert panel will assess whether the injury has indeed been caused by health care, but the patient does not have to go to court and does not have to prove negligence in order to be

[300] PN Kassim, 'No-Fault Compensation for Medical Injuries: Trends and Challenges' (2014) 33 Medicine and Law Journal 21.

[301] AB Kachalia et. al, 'Beyond Negligence: avoidability and medical injury compensation' (2008) 66 Soc Sci med. 387.

eligible for compensation.'[302] In tandem, Weisbrot and Breen observes that any model of the no-fault system is unlikely to be adversarial and may involve panels of peer experts, thus eliminating the issues courts face in hearing from inadequately qualified and biased expert witnesses.[303] Consequently, the no-fault system embodies various legal theories, such as the principles of social insurance, distributive justice, and administrative and risk management.

There are various models and variations in the application of the No-Fault System across different jurisdictions (some of which will be discussed subsequently). However, there exist commonalities between these variations, some of which include the following:

a. set eligibility and threshold disability criteria
b. limitations on the extent of coverage
c. caps on specific categories of compensation
d. compensation for non-pecuniary losses such as pain and suffering may not be available
e. financial compensation levels for comparable injuries tend to be lower in clinical negligence claims brought under delict or tort-based systems
f. simpler and broader access to justice, particularly regarding the costs of initiating or submitting claims, and the time to resolution.
g. access to the courts may be restricted, and the existence of a comprehensive national social welfare and social insurance system in place. [304]

[302] C Vincent, 'Compensation as a duty of care: the case for 'no-fault' (2003) 12 (4) Quality & safety in healthcare 240.

[303] David Wesibrot and Kerry J Breen, 'A no-fault compensation system for medical injury is long overdue' (2012) 197 (5) Medical Journal of Australia 296.

[304] Anne-Maree Farrell, Sarah Devaney & Amber Dar, 'No-Fault Compensation Schemes for medical injury: a review' (2010) Scottish

Based on these variations and commonalities, some jurisdictions have adopted the no-fault system as a stand-alone approach, while others have merged or hybridised it with other administrative designs.[305] Although the no-fault model is still developing in healthcare, it has been used in other sectors, such as automobile insurance and workers' compensation. The following subsection discusses the emergence of the no-fault system in healthcare settings and its evolution over the years.

4.3 The Emergence of the No-Fault System

The history of the no-fault system can be conspicuously traced to New Zealand, the Woodhouse Report dated December 1967, which was coined after the name of Sir Owen Woodhouse, the chair of the Royal Commission of Inquiry. Along with H.L Bockett, Esquire and G.A Parsons, Esquire as members, and J.L Wright as the secretary of the commission, Sir Owen Woodhouse developed the report on the Compensation for Personal Injury in New Zealand. While tort has been proclaimed a deterrence mechanism, it is noteworthy that 'the Woodland report found no evidence that tort acts as a deterrence or reduces claims.'[306] This report led to the establishment of New Zealand's Accident Compensation Corporation (ACC) of 1974 – one of the world's most comprehensive no-fault compensation schemes and the gold standard for other schemes, marking a significant shift from the tort system. Woodhouse's vision laid the groundwork for other jurisdictions

Government Social Research Interim Report, <www.gov.scot/binaries/content/documents/govscot/publications/consultation-paper/2012/08/consultation-recommendations-fault-compensation-scotland-injuries-resulting-clinical-treatment/documents/volume-2- fault-compensation-schemes-medical-injury-review/volume-2-fault-compensation-schemes-medical-injury-review/govscot:document/00403703.pdf> accessed 23 December 2025.

[305] Randal R Bovbjerg and Frank A Sloan, 'No Fault for medical injury: Theory and Evidence' (1998) 67 University of Cincinnati 55.

[306] Barker (n 164).

to consider no-fault models, especially in healthcare.

Following the 1972 Woodhouse Report, the recommendation was legislated, and almost all personal injury litigations were foreclosed.[307] Although the initial scheme did not include medical injuries, the gap was soon covered. Thus, the ACC covers all personal injuries, including those from medical negligence, regardless of fault. It is pertinent to note that the ACC has had more reforms in 2005. These reforms are discussed further in the form of New Zealand's no-fault scheme, discussed in the latter part of this chapter.

As with the Woodhouse Report, the dilemma of the adequacy of the tort debate fuelled the emergence of a no-fault system discourse especially as doctors' liability and incessant suits spiralled. According to Weiler, 'in the late 1970s and early 1980s, doctors were again caught up in a broader spiral of tort liability claims and insurance premiums in the mid-1980s.'[308] With this in mind, the discourse of a no-fault system emerged through a prompt response by legislative reform. In response to the inadequacies of the tort system discussed in Chapter 2, the need to develop a system that prioritises the needs of claimants (patients) by providing fair compensation, timely redress and avoiding the adversarial costs of obtaining justice fuelled the no-fault system movements.

In the late 1980s, Bovbjerg and Sloan noted that in the United States, Virginia became the first state to introduce a no-fault system for medical injuries which was replicated in Florida. Further, they stated, legislative activism led to the enactment of the Birth-Related

[307] A B Kachalla et al, 'Beyond negligence: Avoidability and medical injury compensation' (2008) 66 Soc Science & Med 387.

[308] Paul C Weiler, 'The Case for No-Fault Medical Liability' (1993) 52 (4) Maryland Law Review 908.

Neurological Injury Compensation Acts targeted at removing severe neurological injuries to newborns from tort law. He also noted, 'although small, these programs are significant because they are the only operating examples in the United States of a no-fault for medical injuries-adverse events caused by medical professionals' actions and inactions.'[309]

According to Carlson, it is the patient's burden to find their way into (and occasionally through) the healthcare system,[310] despite the patient relinquishing control to the medical practitioners. In Britain, the Pearson Commission recommended a strict liability approach where plaintiffs would have to prove fault on the part of the defendant. [311]

4.4 The Forms of the No-Fault System

Some jurisdictions have adopted the no-fault system alone, and some have merged it with other administrative designs.[312] As aforementioned, the No-Fault System has been adopted as either a stand-alone or a hybridised system across different jurisdictions, including the United States, New Zealand, Finland, Denmark, Norway, and Sweden. Against this background, this section explores the different forms operable in New Zealand, Sweden, Denmark and the United States as well as their associated successes. These countries have been chosen because they cumulatively have over eighty (80) years of experience in operating administrative systems that entirely replace medical malpractice litigation or have a hybrid system of torts.[313]

[309] Bovbjerg and Sloan (n 305).

[310] Carlson (n 297).

[311] R Smith, 'Compensation for medical misadventure and drug injury in the New Zealand no-fault system: feeling the way' (1982) 284 British Medical Journal 1457.

[312] Bovbjerg and Sloan (n 305).

[313] Studdert and Brennan (n 199).

4.4.1 New Zealand and the No-Fault System

Reputably, the 1972 New Zealand Accidents Compensation Corporation (ACC) Act, covering personal injury, including medical malpractice, and providing compensation for treatment without the need to prove fault, has now become the global gold standard for the no-fault system. Compared to other medical malpractice systems, Bismark & Paterson notes that the 'New Zealand system offers more-timely compensation to a greater number of injured patients and more-effective processes for complaint resolution and provider accountability.'[314] The goal of the no-fault system is to reduce litigation, simplify the process of obtaining compensation and provide necessary compensation and support to injured parties. The system is designed to enhance the public good and reinforce the social contract by providing a fair and sustainable scheme for managing personal injury that minimises the overall incidence of injury in the community and the impact of injury on the community.[315]

New Zealand abandoned the traditional tort-based system for compensating medical injuries in 1974 on an approved government-funded compensation scheme.[316] According to Bismark and Paterson, medical litigation was barred under the ACC Act 1972. The Accident Compensation Act 2001 currently governs the administration of the scheme. Although the previous ACC system retained some residual fault elements, further reforms in 2005 completely removed the fault elements to receive compensation for medical

[314] Marie Bismark and Ron Paterson, 'Update: International Report: no-fault compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety' (2006) 25 (1) Health Affairs 278 <www.proquest.com/scholarly-journals/update-international-report-no-fault-compensation/docview/204632555/se-2> accessed 1 August 2024.

[315] Farrell, Devaney and Dar (n 304).

[316] Bismark and Paterson (n 314).

injuries. As opposed to the traditional adversarial tort system, which is focused on individual responsibility, the notion of the no-fault system is fuelled by a compulsory universal social insurance program.[317]

Initially, the ACC was limited in scope to providing accident compensation coverage for injured workers in motor vehicle accidents. Non-workers were excluded from the scheme unless they were injured in a motor accident, and they later retained their common law rights.[318] The ACC has jurisdiction over preventing injury, collecting personal injury cover levies, determining claims for injuries covered by the scheme and providing entitlements for those eligible, paying compensation, buying health and disability support to treat, care for and rehabilitate injured people and advising the government.[319]

According to Flood, since 1 July 1992, lump sum payments for pain and suffering and loss of enjoyment of life are no longer paid; instead, a disability allowance is paid.[320] He further argued that the New Zealand scheme is biased in its approach to compensation, as it 'gifts' the currently employed more compensation as compared to the loss of income-earning abilities.[321] It is noteworthy that the New Zealand ACC Act has undergone a series of reforms from 1974 to date. Initially, the ACC covers medical misadventure, which is defined as personal injury, including medical, surgical, dental or first aid misadventure.

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[317] LN Karl, New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective' (1983) 33 (1) the University of Toronto Law Journal 81.

[318] Ibid 82.

[319] Farrell, Devaney and Dar (n 304).

[320] CM Flood, 'New Zealand's No-Fault Accident Compensation Scheme: Paradise or Panacea?' (1999) 8 Health Law review 1, 5.

[321] Ibid.

According to Vincent, the New Zealand system 'compensates for injuries caused by medical error and rare mishaps, but generally not for injuries deemed not to result from error.'[322] Whilst appreciating the no-fault system, he noted that an ideal system that guarantees patients' safety must act to 'reduce errors and harm and yet also compensate injuries once they occur.'[323]

According to Barker, the 'scheme does not compensate for disease, infection or ageing; compensation is offered to those who suffer injury not resultant from ordinary consequence, taking the patient's underlying health and clinical knowledge at the time of treatment into account.'[324] He noted further that the Injury, Prevention, Rehabilitation and Compensation Amendment Act 2005 is restrictive, and it excludes themes covered under 'personal injury resulting from a health condition, injury resulting from resource allocation; and injury re[325]sulting from a person unreasonably withholding or delaying consent.'[326] On the other hand, the 2005 reforms led to the expansion of 'medical misadventure' to mean treatment injury, and also removing the fault-based element that was earlier retained in the medical misadventure criteria promoting systems learning from medical errors and the establishment of a reporting mechanism that would be motivated by patient safety concerns rather than placing blame on specific medical professionals.

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[322] Vincent (n 302).

[323] Ibid.

[324] Barker (n 164) 598.

[325] Anne-Maree Farrell, Sarah Devaney & Amber Dar, 'No-Fault Compensation Schemes for medical injury: a review' (2010) Scottish Government Social Research Interim Report, <https://www.gov.scot/binaries/content/documents/govscot/publications/consultation-paper/2012/08/consultation-recommendations-fault-compensation-scotland-injuries-resulting-clinical-treatment/documents/volume-2-fault-compensation-schemes-medical-injury-review/volume-2-fault-compensation-schemes-medical-injury-review/govscot:document/00403703.pdf> accessed 23 December 2025

[326] Ibid.

Regarding what injuries are covered under the New Zealand model, it is important to state that mental injuries per se,[327] physical injuries suffered before birth, and compensation for failed sterilization or unplanned children are not covered. Under the New Zealand no-fault system, patients who suffer an injury caused by medical treatment rather than an underlying health condition are automatically eligible for compensation without the need to prove negligence.

The New Zealand model is funded by a variety of sources. According to Flood, the ACC scheme is financed from four sources: employers' earners, motor vehicle owners/users, general taxation revenues, and the premiums employers pay are adjusted per the risks associated with their industries.[328] For example, the work account is funded by premiums paid by employers to cover work-related injuries; on the other hand, the motor vehicle owners' account is funded by injuries involving motor vehicle accidents on public roads. Additionally, the treatment injury account covering injuries from medical care is financed through the earner[329] and non-earner accounts.[330] Other subsidiary accounts include the self-employed work account amounting to work-related injuries to self-employed workers, including private domestic workers, and the residual claims account covers claims for work injuries sustained before 1 July 1999 and non-work

[327] except caused or a material cause of physical injuries or by criminal acts when the claimant was a resident in New Zealand. The claimant must also show that the mental injury resulting from the physical injury was clinically severe.

[328] Flood (n 320).

[329] This is for non-injuries suffered by individuals in paid employment, excluding vehicle accidents. The Earner Account funds are used to meet the costs of injuries from treatment for claimants who were paid in employment before the injury.

[330] This account covers injuries to people who are not in paid employment, such as students, beneficiaries, retired people, and children. The Non-Earner Accounts funds are used to cover claimants' medical expenses for injuries if they were not earning a living before the injury.

injuries prior to 1 July 1992 that were still being managed. Despite these sources of funding, financing has remained a significant challenge.[331]

In the event of a personal injury, a claimant must submit a claim to the ACC for personal injury within 12 months after the date on which they suffer such personal injury. For a treatment injury, it must be within 12 months of the date they incurred the treatment injury or the date a qualified health professional first considered it to be a treatment injury or the date that the person suffered the treatment injury, whichever is the later.[332] The date when an individual first seeks or receives treatment for symptoms, regardless of whether a diagnosis of treatment-related harm exists, is deemed the date on which the individual sustained the treatment injury.

When making a claim before the ACC, a registered health practitioner must help a claimant fill out a claim form to be submitted to the ACC. Following this, the claim is registered, and a unique claim number is then assigned to it. If a claim is approved for ACC coverage, the claimant will receive reimbursement for some associated costs with their initial visit to a health practitioner. Unless the ACC determines that further information is required, most personal injury claims are assessed at the registration centre within 21 days of submission. If there are no 'complicated claims,' there is a maximum time limit of four months if additional information is necessary- a category treatment injury falls under.[333] In

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[331] Anne-Maree Farrell, Sarah Devaney & Amber Dar, 'No-Fault Compensation Schemes for medical injury: a review' (2010) Scottish Government Social Research Interim Report, <https://www.gov.scot/binaries/content/documents/govscot/publications/consultation-paper/2012/08/consultation-recommendations-fault-compensation-scotland-injuries-resulting-clinical-treatment/documents/volume-2-fault-compensation-schemes-medical-injury-review/volume-2-fault-compensation-schemes-medical-injury-review/govscot:document/00403703.pdf> accessed 23 December 2025.

[332] Accident Compensation Act 2001, s. 53 (3) & (4).

[333] Accident Compensation Act 2001, s. 56 & 57.

complex claims, the ACC must inform claimants that further information from a third party (a health professional or expert) may be needed within 2 months of filing, the request must have been made 4 months later, and the claimant should be notified accordingly. Whilst the claimant and the ACC may concur on further extensions, the ACC has 9 months to determine whether to offer coverage.[334] Further, the claimant shall be presumed to have coverage if the ACC does not reach a decision regarding coverage during this designated period.[335]

New Zealand's system makes for compensation for [336]treatment and rehabilitation, including the costs of disability aids, home modifications, and vocational training. Compensations have also been made for loss of earnings, paying up to 80% of earnings at the time of injury, up to a set maximum of NZ$41,692.59 weekly. Claimants can also get a one-time lump sum compensation if the injury occurred after 1 April 2022. Additionally, compensation is made to support the surviving spouses of an injured person who is deceased and children under 18. [337]

Another interesting aspect of the New Zealand scheme is that if a New Zealander is injured whilst travelling abroad for a short trip, whether for business or fun, not exceeding 6 months, they may be covered by the ACC and can make a claim upon their return.

Bismark & Paterson acknowledge that New Zealand has strong health and welfare

[334] Accident Compensation Act 2001, s. 57.

[335] Accident Compensation Act 2001, s. 58(1).

[336] Accident Compensation Act 2001, s. 79 & 80.

[337] Bismark and Paterson (n 314).

systems that cover many damages, although the compensation paid out is relatively low compared to what may have been received under a malpractice system.[338] Nonetheless, New Zealand's no-fault model, unlike the conventional tort system, allows for a quicker process and does not require proof of fault. This ensures that all patients with injuries from treatment received are compensated. This has significantly reduced medical malpractice suits in New Zealand, encouraged patient safety, and strengthened the patient-physician relationship.

4.4.2 Sweden and No-Fault System

Prior to 1975, medical injury compensation followed the same guidelines as other personal injury compensation, with culpability and vicarious liability standards holding a physician or hospital/chief officer accountable, leading to the difficulty in establishing fault and causation, leading to lawsuits being rare and mostly dismissed.[339] This led to a series of Swedish tort system reforms and the Patient Injury Insurance introduction in 1975. The goal was to enhance accessibility and re-allocate resources to the right channels rather than dispensing them on administrative, legal fees and court trials.[340]

The Swedish system operates two distinct schemes: (1) the Pharmaceutical Insurance Scheme and (2) the Patient Insurance Scheme.

The Pharmaceutical Insurance Scheme, which started in 1978, was founded on an

[338] Ibid.

[339] Sabina Hellborg, 'Patient Injury Compensation for Health-related Injuries in Sweden' (2019) 23 (2) Journal de Droit de La Santé et de l'Assurance Maladie 62 < https://su.diva-portal.org/smash/get/diva2:1369246/FULLTEXT01> accessed 3 August 2024.

[340] Ibid.

agreement between Swedish drug companies (and the Swedish representatives of foreign drug companies) and the same insurance consortium. The Pharmaceutical Insurance Scheme is funded entirely by contributions from the drug companies in proportion to their turnover. A condition of this scheme is that a patient accepting compensation will not have the right to sue at Common Law. The patient is required to assign his rights to the consortium, which has, in turn agreed with the drug companies not to sue them or their parent companies. The basic principle of both schemes is that it is necessary to establish causation between the medical treatment (or the drug) and the injury suffered. Still, it is not necessary to prove negligence.[341]

On the other hand, the Patient Insurance Scheme has been in operation since 1975. It is important to note that these schemes are voluntary. This means they are not mandated by statute but are universal, covering all aspects of healthcare and pharmaceutical products available in Sweden.[342] Compensation is provided without proof of provider fault, addressing the issue that patients could not access compensation under the tort system.[343]

The Patients Insurance Scheme is founded on an agreement between the Swedish County Councils (which act as health authorities) and the consortium of Swedish insurance companies that insure the claims under the scheme. Patients who suffer injuries because of medical care file a claim under the scheme, but they retain their common law right to file a tort lawsuit. The councils pay the insurance consortium a premium and acknowledge

[341] Malcoms Braham 'The Swedish "No Fault" Compensation System for Medical Injuries_ Part I' (1988) 138 The New Law Journal 14; Henry Johansson, 'The Swedish system for compensation of patient injuries' (2010) 115(2) Ups Journal of Medical Science 88.
[342] Ibid

[343] Ibid.

liability for medical accidents.[344]

It is an administrative scheme that compensates for certain types of injuries. Under the patient's scheme, the accidents that are compensated cover injuries caused to a patient during medical treatment but do not cover injuries suffered as a result of a public health measure. An injury is due compensation if, by 'the preponderance of the evidence,' it was caused by medical care, and treatment was not either medically justified or could have been avoided, given customary care. Nonetheless, under the patient compensation insurance scheme, there is no proof of fault or negligence of an individual provider.[345]

Physical and mental injuries are typically covered, but a causal link between the injury and the medical care must be established, showing that the injury could have been avoided. For example, claims will only be accepted if the patient has experienced illness for a minimum of 30 days, has been hospitalised for at least 10 days, has suffered permanent disability or has died, and costs for treatment and loss of income exceeding £100 are consistently indemnified. Compensations are usually for unforeseeable injury. In accessing compensation, Hellborg noted that:

> [T]he system of compulsory patient insurance aims at repairing damage caused by specific actions in health care. Responsibility according to The Patient Injury Act does not require any fault on behalf of the caregiver, and damages are not reduced because of contributory ne gligence of the person suffering damage. This means that

[344] Brahams (n 341).

[345] Henry Johansson, 'The Swedish system of compensation of patient injuries' (2010) 115 (2) Upsala Journal of medical Sciences 898.

the question of causation is of much greater importance than the question of fault.[346]

Consequently, patients are not left without an option in the event of foreseeable damage in seeking compensation, for example, scarring due to a procedure. Such compensation will then be pursued via tort as an act of negligence. Generally, the most compensable injuries are diagnostic, treatment, and infection-related injuries.[347] Danzon highlighted that the patient compensation insurance scheme garnered two perspectives, one from patients and the other from physicians. He highlighted that although physicians generally felt the scheme was truly a no-fault scheme, patients felt otherwise, expressing that the criteria for determining compensation were quite like traditional based torts standards.[348]

The Swedish no-fault system states that a claim must be filed within three years of learning about the injury and within 10 years of the injury happening.[349] To claim for compensation, patients are required to complete a simple form with the assistance of hospitals or clinic personnel. Such claims are administered by the monopoly of a consortium of insurers. Where a patient is dissatisfied with the insurer's decision, an appeal may be submitted to the Patient Claims Panel. The panel is a committee that is part of the patient injury system, issuing advisory opinions in compensation cases referred to it by patients, care providers or an insurer.[350] The panel consist of a chairman, who is or has been a professional judge, and six members, including three members that represent the

[346] Hellborg (n 339); See also Patient Injury Act, s. 6.

[347] Johansson (n 345).

[348] Danzon PM, 'The Swedish Patient Compensation System: Myths and realities' (1994) 14 International Review of Law and Economics 453.

[349] Kachalla et al. (n 307).

[350] Johansson (n 345).

patient's interest; one is a medical expert, one is familiar with the insurers' personal injury settlement process, and one is an expert in the Swedish health care system.[351] Patients may further appeal to arbitration through the general Swedish arbitration system because the panel's decision is merely advisory and not binding.

It is important to note that compensations (indemnity) awarded under the Swedish no-fault system can be pecuniary or non-pecuniary damages. The former covers loss of income and medical expenses arising from an injury not covered by other insurance, while the latter compensates for pain and suffering, disability and disfigurement, and inconvenience.[352]

Under the Swedish system, successful claims do not result in financial losses, reputational damage, or moral responsibility for individual providers. This fosters an open forum for discussion and encourages disclosure while undermining the concept of deterrence. Although there is no public naming and shaming of the individuals responsible for the injuries caused, hospitals and clinics are made aware of their claim's experience, while the underlying causes of the preventable injuries remain unidentified.[353] Notably, under this system, patients can still file claims with the Medical Responsibility Board in charge of discipline of medical providers, where, following an investigation, they can issue a reprimand or a warning to the provider with no financial consequences for either the patient or physician. Also, there is no communication between the Patient Compensation Insurance and the Medical Responsibility Board to encourage physician cooperation with

[351] Ibid.

[352] Hellborg (n 339).

[353] Danzon (n 348).

the patient compensation insurance scheme. [354]

4.4.3 Denmark

The Danish no-fault system was established under the Patient Compensation Act 1992, with the goal of improving patients' access to compensation if they suffer unexpected injuries while receiving care without the need to prove mistakes.[355] This was in response to the difficulty in making a claim before a judge in court to claim compensation for an injury and the need to develop a publicly funded compensation scheme like that of Sweden.[356]

Consequently, the Patient Compensation Association, now the Danish Patient Compensation, was founded as an independent association to assist patients in leading their cases and evaluate if they are entitled to compensation due to injuries in healthcare.[357] The types of injuries covered under the Danish system are treatment, diagnostic, equipment-related and accident-related injuries (negligence).

Claimants are not charged to file a claim, and they require no medical support to file a claim, as claims can be made online. In situations where the patient is disabled or has passed away, family members may start the claim.[358] Under the Danish system, two rules determine how claims are evaluated – the avoidability rule and the endurability rule. The former issued in

[354] Ibid.

[355] Khan Nissa et al., 'No-Fault Compensation from the Patient Compensation Association in Denmark After Primary Total Hip Replacement in Danish Hospitals 2005-2017' (2020) 35 (7) The Journal of Arthroplasty 1784.

[356] Danish Patient Compensation <https://eng.patienterstatningen.dk/about-us/history> accessed 1 January 2025.

[357] Ibid.

[358] Nissa et al., (n 355).

place of negligence in determining which injuries are entitled to compensation, compensating injuries that could have been avoided, and similar to Sweden, it uses 'the experienced or best specialist standard for defining avoidable injury and also applies the 'alternate treatment rule' to compensate equipment-related injuries.[359] On the other hand, the latter is used in evaluating if compensation should be paid for unavoidable medical injury if it is an unusual and serious injury in relation to medical care received by a patient.[360]

In determining claims before it, Danish Patient Compensation may use a specialist doctor to evaluate whether a patient injury has occurred, whether the treatment was suboptimal, and the caseworker will decide whether the patient is entitled to compensation. The deadline for making a claim is 5 years from when the claimant became aware of the injury and no more than 10 years from the date of the injury occurring. However, the average processing time for a claim is about 9 months,[361] which is faster than traditional litigation.

Compensations are paid for pecuniary, like loss of earnings, ability to work, permanent damages, etc, and non-pecuniary damages cover compensation for pain and suffering. Family members are allowed to make a claim on behalf of a patient who has died during treatment and may receive entitlements for funeral expenses and loss of dependency. The Danish system ensures that most of the compensation is paid out immediately after the compensability decision, and most cases are fully compensated and closed within a year.[362] The Danish no-fault system is largely government-financed with, 85% being generated

[359] Farrell, Devaney and Dar (n 304.

[360] Ibid.

[361] Danish Patient Compensation (n 356).

[362] Nissa et al., (n 355).

through taxes and 15% being privately generated from pharmaceuticals and dentistry.[363]

Further, the Danish system recognises that a compensation system does not exonerate professional accountability of medical practitioners, which the Danish Agency handles for Patient Complaints. Thus, a patient retains the right to claim for compensation following a treatment injury and still make a complaint against a medical practitioner.

In ensuring patients' safety and preventing medical errors, feedback is provided to the hospitals. When a single hospital department has an unexpectedly large number of medical injuries in a short time, the Danish Region that owns the hospital will automatically be informed of this.

4.4.4 United States

The United States does not have a nationwide application of the no-fault system in dealing with medical negligence disputes. While the American legal system is primarily tort-based, some states have adopted the no-fault system alongside torts in resolving medical negligence disputes, such as in Virginia and Florida.[364] These states have established selective no-fault schemes can be used in seeking compensation, for example, compensations covering birth-related neurological and vaccine injuries.[365]

Given the numbers of litigation claims and the cost of premium insurance for medical practitioners, the Florida and Virginia Birth-Related Neurological Injury Compensation

[363] Ibid.

[364] William J Gaine, 'No-faults compensation systems' (2003)10 British Medical Journal 997.

[365] Farrell, Devaney and Dar (n 304).

Programs were established, with the aim of providing prompt compensation to the families of children who suffered catastrophic birth injuries whilst also protecting medical practitioners and hospitals from prolonged and costly malpractice litigation. Virginia enacted its Birth-Related Neurological Compensation Act, 1987 setting the pace for no-fault scheme, whilst Florida established its Birth-Related Neurological Injury Compensation Act. The Virginia system was managed by the Workers' Compensation Commission (WCC), and Florida's system was managed by the Birth-Related Neurological Injury Compensation Association (NICA).

Under the Florida scheme, to be eligible for compensation, the injury must be birth-related, that is, injury to the brain or spinal cord of a live infant weighing at least 2.5kg for a single gestation. Where it is the case of a multiple gestation, injury will be considered for a live infant weighing at least 2.0 kg at birth caused by oxygen deprivation or mechanical injury occurring during labour, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. The limitation is that patients can also benefit from the scheme if their doctors participate in the scheme by paying annual premiums. Similarly, in Virginia, an injury must be birth-related, and the physician carrying out the obstetrics services must participate in the scheme including the hospital where the services were rendered. Both Florida and Virginia exclude disability or death caused in the cause of the services and only apply the scheme to live births. As in the tort system, legal representation is always required to determine birth-related neurological injury to process a claim under the schemes. Compensations usually cover costs including for services, medications, facilities,

equipment, travel, excluding those already compensated by the state or federal government or private insurers; non-pecuniary compensation, the death benefit for the infant, and reasonable expenses for filing a claim, including reasonable legal fees.

While Florida and Virginia have attempted to adopt the no-fault system in resolving negligence claims, for example, with quicker resolution of claims, it is evident that the limitations of the statutory eligibility criteria reduce the efficiency of this scheme. This is exacerbated by the cost of premiums for physicians and hospitals among other issues.[366]

4.5 The No-Fault System: A Step in the Right Direction?

No-fault compensation in medical negligence cases has garnered significant attention as an alternative to traditional tort-based litigation. Herein, the regime of no-fault compensation in New Zealand, Sweden, Denmark, and the United States is examined, especially how it has encouraged patient participation in the dispute resolution and compensation process.

Whilst the no-fault system has received considerable approval for its merits, it has been debated as an effective alternative to the tort system for compensating patients who have experienced medical negligence.[367] Consequently, the jurisdictions examined have shown that one of the core values of the no-fault system is the expedited compensation for patients. Compared to the long delays patients face in the traditional tort system, where

[366] Frank A Sloan et al, 'The road from medical injury to claims resolution–how no-fault and tort differ' (1997) 60 Law and Contemporary Problems 35.

[367] David M Studdert et al. "Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?" (1997) 60 (2) Law and Contemporary Problems 1.

access can go for years, the average processing times under the no-fault scheme is less than 12 months. It shows a clear roadmap on how and when redress can be sought, providing a patient-centred approach to the administration of justice. However, Bismark et al. in analysing the success of the no-fault system in New Zealand, undertook a study that links the national claims database (Accident Compensation Corporation) to records from the New Zealand Quality of Healthcare Study (NZQHS).[368] They concluded by their analysis and collected data that there is a significant underclaiming by injured patients as the proportion of injured patients to those who seek compensation in New Zealand is very low.[369]

Further, by generating data on the incidences of medical errors and negligence in the healthcare system, the no-fault system encourages systemic learning and improvements. This will lead to targeted interventions and reforms of the health system. Further, it eliminates the incidences of the practice of defensive medicine, reducing the strain on medical professionals due to rising insurance costs, liability provisions, and lawsuit risks, fostering trust and healthy patient-physician relationships.[370]

Weisbrot and Breen, adopting the 2011 Australian Productivity Commission report, noted that one of the potential benefits of the system is that it is a more efficient system for delivering more care and support to injured patients regardless of the circumstances under

[368] Bismark et al, 'Claiming behaviour in a no-fault system of medical injury: a descriptive analysis of claimants and non-claimants' (2006) 185 (4) Medical Journal of Australia 203.

[369] Ibid.

[370] Michelle M. Mello and Troyen A. Brennan, 'Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform' (2002) 80 Texas Law Review 1595; David M. Studdert, 'Claims, Errors, and Compensation Payments in Medical Malpractice Litigation' (2006) 354 (19) The New England Journal of Medicine 2024; Allen Kachalia and Michelle M. Mello, 'New Directions in Medical Liability Reform' (2011) 364(16) The New England Journal of Medicine 1564.

which the person was injured.[371] Further, he noted that in the context of medical indemnity, a no-fault scheme has the potential to improve the mindset of medical practitioners on patient safety, provide a learning reference from their own mistakes and others' mistakes to prevent errors, and ultimately reduce the practice of defensive medicine.

The funding and financing of the no-fault scheme, which is primarily funded by national social security systems is another challenge due to the rising costs of compensation payouts, since eligibility is contingent on no requirement to prove faults. This is likely to burden the system and encourage higher insurance levies. For example, New Zealand's ACC has occasionally experienced financial issues, necessitating government action to guarantee ongoing funding.[372] These issues highlight the need for sustainable funding solutions, such as hybrid public-private funding arrangements or mandated provider levies.

Whilst the no-fault system enjoys a relatively faster administrative disposition of claims, the eligibility threshold remains an inhibiting factor to injuries not covered under the scheme, making it inherently unfair and biased.[373] Identifying which medical injuries are eligible for no-fault compensation is challenging and arbitrary. The 'preventability' or 'avoidable harm' standards used by most no-fault systems can be interpreted differently, resulting in inconsistent outcomes.[374]

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[371] Weisbrot and Breen (n 303).

[372] Memorandum from Nicola Carroll BL to Mr. Justice Charles Meenan (8 October 2018), 'Expert Group on Tort Reform and Management of Clinical Negligence Claims – No-fault Compensation Schemes in New Zealand and Other Countries.'

[373] Richard Smith, 'Problems with A No-Fault System of Accident Compensation' (1982) 284 British Medical Journal (Clinical Research Edn) 1323.

[374] Anne-Maree Farrell & R Frowde, 'No-Fault Is No Panacea: Examining No-Fault Compensation Schemes for Medical Injury' (2021), The Manson Institute Blog, <https://blogs.ed.ac.uk/mason-institute/2021/10/14/no-fault-is-no-panacea-examining-no-fault-compensation-schemes-for-medical-injury-by-anne-maree-farrell-and-rhiannon-frowde/> 1 January 2025.

In conventional malpractice regimes, medical personnel are frequently deterred from acknowledging medical errors by the threat of legal action. By enabling practitioners to participate in open disclosure and learning without fear of legal repercussions, no-fault systems help to reduce this problem.[375] This promotes openness by allowing doctors to acknowledge mistakes, express regret to patients, and work together to enhance safety protocols and guarantee patients' trust in the healthcare system. Nonetheless, some critics have argued that the system has failed to provide an incentive to the medico-legal system – doctors, patients or administrators – to ensure high levels of care.[376]

Consequently, the no-fault systems have demonstrated the capacity to expedite compensation, reduce litigation costs, encourage open disclosure, and foster systemic learning to prevent future medical errors in jurisdictions where they have been successfully implemented.

4.6 Conclusion

In many jurisdictions, the no-fault system has proven to be a practical and effective alternative to tort-based litigation in medical negligence disputes. This approach enables quicker compensation, reduces legal costs, and creates a safer, more educational healthcare environment. No-fault plans promote open disclosure, enhance access to compensation, and foster a learning culture within healthcare systems by eliminating the requirement for claimants to prove negligence to receive compensation.

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[375] Bismark et al. (n 251).

[376] Memorandum from Nicola Carroll BL to Mr. Justice Charles Meenan (8 October 2018), 'Expert Group on Tort Reform and Management of Clinical Negligence Claims – No-fault Compensation Schemes in New Zealand and Other Countries'.

This chapter has undertaken a comparative analysis of the existing models of the no-fault scheme in New Zealand, Sweden, Denmark and the United States as a viable alternative to tort for other jurisdictions, such as Nigeria, facing challenges with the administration of tort-based litigation. This analysis evaluated the eligibility criteria, funding, filing and processing of claims. Notably, the capacity of no-fault regimes to promote openness and transparency in medical practice is among its most important benefits. Healthcare providers are more likely to disclose problems, communicate with patients, and participate in safety improvement projects when they are not afraid of being sued. Tort-based litigation, which frequently deters medical personnel from candidly sharing unfavourable events out of concern for potential legal ramifications, contrasts sharply with this move towards systemic learning and preventive actions. As a result, no-fault programs have been praised for improving the rapport between patients and providers and encouraging a proactive approach to patient safety improvements.

This chapter has also discussed some of the drawbacks of the no-fault schemes, such as compensation caps, financial sustainability, etc. Whilst the no-fault scheme compensates for targeted interventions, there are still gaps within the system that do not cater to every patient's need. For example, eligibility requirements, streamlining funding processes, and balancing systemic learning with personal accountability remain unsolved challenges. Thus, an approach to filling these gaps may be merging the no-fault system into other schemes, such as the restorative justice system, to provide both financial and emotional support to injured patients (discussed in the subsequent chapter). It is also recommended that future studies should explore methods to enhance eligibility requirements, streamline

funding processes, and balance systemic learning with personal accountability to ensure that no-fault schemes continue to evolve as fair and enduring solutions in medical law.

Overall, no-fault compensation plans offer a practical, patient-centred substitute for drawn-out legal proceedings, providing a fair and impartial handling of medical malpractice cases that emphasizes effectiveness, openness, and systemic learning. The achievements of New Zealand, Sweden, Denmark, and the United States show the possibility for a more equitable and easily accessible compensation framework in healthcare law, even though issues with sustainability, eligibility requirements, and accountability need to be addressed. Policymakers and legal experts must continue to evaluate and improve no-fault models as the global healthcare sector changes to guarantee fair and long-lasting results for patients and healthcare providers.

CHAPTER FIVE

INTEGRATING THE PRINCIPLES OF RESTORATIVE JUSTICE AND NO-FAULT SYSTEMS IN RESOLVING MEDICAL NEGLIGENCE DISPUTES IN NIGERIA: LEVERAGING THE AFRICAN RESTORATIVE JUSTICE SYSTEMS

5.1 Introduction

Patients' safety is significantly undermined by recurring incidents of medical negligence within the Nigerian healthcare system. In resolving disputes arising from negligence threatening patients' safety, the tort system has been used as a medium of adjudication, as discussed in Chapter 2. While this system of adjudication enjoys global and conventional popularity, the unresolved puzzle is whether it is an ideal solution for resolving medical negligence disputes in Nigeria. The tort system prioritises determining liability before awarding damages to aggrieved parties, emphasising deterrence and compensation over reconciliation, healing, and restoration. Similarly, alternative measures, such as ADR (discussed in Chapter 2), have been enacted to enhance the tort adjudicatory system. Nonetheless, the needs of patients in accessing justice are still unmet through these channels. Thus, there is an urgent need to identify and establish a functional legal infrastructure that adopts a patient-centred approach to resolving medical negligence disputes in Nigeria, prioritising patient safety, healing, restoration and compensation.

Chapter 2 of this thesis discusses the fallibility of the tort system, indicating that it is unfit for use because medical negligence claims in Nigeria are still mired in adversarial, expensive, and protracted litigation processes that fail to provide injured patients with justice in record time. In response to these challenges, this chapter discusses the African

Restorative Justice System (ARJS) as a potential medium for resolving medical negligence disputes in Nigeria. Although restorative justice and no-fault compensation systems have been discussed in Chapters 3 and 4 of this thesis, this chapter critically evaluates how these models, rooted in the native African philosophy of Ubuntu, could be effectively integrated into Nigeria's legal and medical systems. Thus, this chapter advocates for a holistic framework incorporating Ubuntu's philosophical tenets as a viable medium that resonates with the Nigerian culture to advance restorative justice and the no-fault compensation system in addressing medical negligence disputes within the Nigerian healthcare system.

Further, unlike Western countries that are primarily individualistic and self-autonomous, Nigeria is a society rooted in communal values and collective relationships.[377] This chapter discusses whether, given the communal values entrenched in the Nigerian culture, an integrated system comprising Ubuntu, restorative justice, and a no-fault model efficiently addresses medical negligence disputes in Nigeria. Is it possible for this integrated model to strengthen patient safety? To what extent will Nigerians be receptive to adopting the integrated model to resolve medical negligence, considering its legal and cultural nuances in addressing these disputes? These critical questions need not be ignored; hence, this chapter aims to answer these questions.

Moreover, anecdotal evidence suggests fewer cases of medical negligence disputes instituted or pending in the Nigerian court than the many reported cases of medical negligence in the media, especially on social media. Additionally, the Nigerian court has

[377] Ashley Humphrey and Ana-Maria Bliuc, 'Western Individualism and the Psychological Wellbeing of Young People: A Systematic Review of Their Associations' (2022) 2 (1) Youth 1 <www.mdpi.com/2673-995X/2/1/1> accessed 22 September 2024.

no centralised database or published judicial statistics on medical negligence cases. One of the reasons for having disparities between occurring medical negligence cases and those filed in court may be associated with the current fault system, which makes it strenuous, if not impossible, to file a claim, pursue and successfully resolve these medical negligence claims. Thus, this chapter proposes a holistic framework that seeks to overhaul the healthcare systems by improving patient safety guarantees, thereby improving the overall satisfaction of patients, medical practitioners and other stakeholders. This is possible by combining the restorative justice approach and a no-fault compensation scheme that meets the procedural and administrative justice needs of patients and substantive justice demands of patients in Nigeria, respectively, through the lens of Ubuntu. This is achieved by creating a less adversarial, more accessible and transparent dispute resolution mechanism.

Recognising the need for a paradigm shift in the legal mechanisms addressing medical negligence in Nigeria, this chapter explores an integrated no-fault system, Ubuntu, and restorative justice model. This model will serve as a pivotal path towards equitable compensation and the repair of harm between patients, medical practitioners, and other stakeholders in Nigeria, unlike the conventional tort system, which requires injured patients to overcome significant evidentiary hurdles in establishing fault, making the system less accessible and untransparent for the injured party on the path to accessing justice for medical injuries suffered in the process of receiving care.

5.2 The African Restorative Justice System (ARJS) and the Ubuntu Philosophy

ARJS emphasises communal values, interdependence, interconnectedness, and collective responsibility. According to Wielenga, Batley, and Murambadaro, ARJS prioritises 'social harmony and the interconnectedness of the community.'[378] Prior to colonialism, disputes within African societies were resolved through traditional methods and informal justice approaches,[379] which differ from the Western form of dispute resolution. Whilst the Western form of dispute resolution promotes retributive justice, African systems promote the restoration of relationships for collective healing. Schoeman noted that 'in traditional Africa, the concepts of Ubuntu, community, indigenous justice, and restoration are interlinked.'[380] Furthermore, Ramose stated that 'Ubuntu is the basis of African law.'[381]

Ubuntu is coined from the short form for an isiXhosa maxim from Southern Africa, and the maxim is 'Umuntu Ngumuntu Ngbantu,' which means 'an individual is an individual through their relationship with others.'[382] Mbiti defines this as 'a communitarian thesis of I am because you are; and because you are, therefore I am.'[383] This analogy describes what is referred to as true African justice based on principles of restoration and

[378] Cori Wielenga, Mike Batley and Ruth Murambadoro, 'Beyond Restorative Justice: Understanding Justice from an African perspective' (2020) 9 (1) African Journal of Peace and Conflict Studies 23.

[379] D J Omale, 'Justice in History: An Examination of 'African Restorative Traditions' and the Emerging 'Restorative justice Paradigm' (2006) 2 (2) African Journal of criminology and justice Studies 33.

[380] Schoeman M, 'The African concept of Ubuntu and Restorative justice' In Theo Gavrielides and Vasso Artinopoulou (ed) *Reconstructing Restorative Justice Philosophy* (1st edn, Routledge 2013).

[381] Mogobe B Ramose, 'African Philosophy through Ubuntu' (Mond Books, 1999) 72.

[382] Itunu O Ilesanmi et al., 'Agbajo owo la fin soya ajeji owo kan ko gberu de ori': A social work perspective on the collective action of the EndSARS protest' In *Ubuntu Philosophy and Decolonising Social Works Fields of Practice in Africa* (1st ed., Routledge 2023).

[383] Mbiti (n 8).

forgiveness.[384] Ubuntu has also been described as how African societies view the world and a determining factor in forming perceptions that influence social conduct.[385]

This African principle of justice values the responsibility of all those involved in an incident to restore the unbalanced and broken relationship caused by the incident, as opposed to the Aristotelian concept of corrective justice, which focuses primarily on ensuring that a wronged party receives monetary compensation equivalent to the harm suffered in addition to treating the dispute as an isolated event between the two parties.[386] This contrasts with the African Ubuntu that extends beyond the parties and emphasises the community's communal well-being, reconciliation and restitution of trust.

In *S v Makwanyane and Another*, the court noted that 'Ubuntu is a shared value and ideal that runs like a golden thread across cultural lines.'[387] Ubuntu seeks to promote reconciliation and accountability for redressing harm caused, providing an opportunity for those injured to participate and be compensated. This prevents stigmatisation within the system and is a win-win outcome for all involved. Genger identifies the tenets of African restorative justice as consisting of the following: humanism, personhood, community and harmony, common good, and duty and responsibility.[388]

Humanism, as one of the core values of Ubuntu, emphasises an anti-individualistic

[384] J Jumbe Gabagambi, 'A Comparative Analysis of Restorative Justice practices in Africa' (2018) 3, GlobaLex <www.nyulawglobal.org/globalex/Restorative_Justice_Africa.html> accessed 10 October 2022.

[385] Yvonne Mokgoro, 'Ubuntu and the Law in South Africa' (1998) 4 Buffalo Human Rights Law Review 15.

[386] Weinrib (n 4).

[387] [1995] 3 SA 391 (CC)

[388] Peter Genger, 'Combating Corruption with African Restorative Justice Tradition: Suggested steps for Nigeria' (2018) 11 (1) African Journal of Criminology and Justice Studies 25.

approach to life within a given community. It shows that life combines spiritual and communal elements that submit to the Supreme Being and ancestors. It shows the importance of treating everyone with respect and that life must be treated with sacredness. Although Ubuntu transcends any religious or spiritual confinement, the African values and doctrines are seen as spiritual.[389] Whilst Ubuntu recognises that causing harm to human life is abominable and punishable, it nonetheless reflects that even in cases where harm has been caused those involved must be treated with dignity and without dehumanisation. According to Ilesanmi et al. 'Ubuntu is perceived as the African way of thinking of humanism, connecting the person to the aggregate through 'fraternity' or 'sisterhood.'[390] Indeed, Ubuntu emphasizes the fellowship of humans.

Personhood conceptualises the relational existence of Africans. It pinpoints that humans are a product of their relationships with others, as they do not exist in isolation. Genger noted that 'personhood in African vision has the Hobson's choice of living interdependently irrespective of one's success, power, status and wealth.'[391] He noted further that Africans who are 'culpable of corrupt acts are by implication bereft of personhood.'[392] This loss of personhood underscores the relational aspect of African justice that links an individual's moral status to their conduct in the community.

Community and Harmony in Ubuntu is a concept of communitarianism vis-à-vis personal responsibility. It is a philosophy that considers group solidarity as central to the survival

[389] Mokgoro (n 385).

[390] Ilesanmi et al. (n 382).

[391] Genger (n 388).

[392] Ibid.

of the community and asserts that a human being is only human because of other humans.[393] Ramose views African law as fostering a 'family atmosphere' among the African people.[394] It highlights the true essence of human existence as being developed through communal relationships, where a shared community sustains personhood and where community members are readily available to pool resources to support individual needs.[395] This underlines the idea that African justice seeks to restore harmony when disrupted by wrongdoing. It illustrates the collective impact of harm on the victim and the larger society; therefore, healing extends to the community affected by the wrongdoing. It promotes a sustainability model where society is never lacking.

Regarding communitarianism, Keevy noted that 'as an outcast, the offender not only loses his status in the community but also his ability to participate in communal activities until his offence is purged and his status restored.'[396] Therefore, ARJS fosters collective shame that affects not only the primary 'offender' but also their peers and family who usually take collective responsibility for their actions.[397] This encourages deterrence, prevention of future re-occurrence of such 'shameful' action, and taking responsibility for actions not applauded in the community. Although it has been argued that torts provide a deterrence effect,[398] based on rising numbers of medical negligence cases, it is arguable

[393] Mokgoro (n 385).

[394] Ramose (n 381) 72.

[395] Mokgoro (n 385).

[396] I Keevy, 'Ubuntu versus the core values of the South African constitution' (2011) 32 Journal for Science 19.

[397] Julia L Sloth-Nielsen and Jacqui Gallinetti, ''Just Say Sorry?' Ubuntu, Africanisation and the Child Justice System in the Child Justice Act 75 of 2008.' (2011) 14 (4) Potchefstroom Electronic Law Journal 63.

[398] Andrew Popper, 'In Defense of Deterrence' (2011) 75(1) Articles in Law Reviews & Other Academic Journals 181 < https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1297&context=facsch_lawrev> accessed at 2 January 2025.

that the deterrence effect is unreal.[399]

Common Good inherently speaks to the commonwealth of the community in that Ubuntu serves the interests of the larger community, not just persons directly affected by the wrong committed. Thus, the goal of the African justice system is to create outcomes that are beneficial to the larger community.

Duty and Responsibility reflect the fulfilment of communal obligations of individuals towards one another within the African community. It shows that individuals are responsible for their actions or inactions and are obliged to contribute to the well-being of others and the larger community. It also emphasises those who have caused harm or done wrong to own their actions, apologise and make necessary reparations to those directly affected by their actions/inactions and the community. As Grenger puts it, 'all legal, political, economic, moral and other social processes are duties and responsibilities to be pursued with passion, solidarity, reciprocity, cooperation, interdependence, as well as a sincere commitment toward the community and its members.'[400]

Ubuntu has profoundly influenced post-apartheid legal frameworks in countries where it has been adopted, particularly South Africa, which prioritises restorative justice and reconciliation over retribution. Although Ubuntu remains deeply rooted in South Africa, it resonates with other African communities,[401] including Nigeria. For instance, the Yoruba ethnic group of Nigeria embodies this unity through a wealth of proverbs ingrained in the

[399] Michelle M. Mello and Troyen A. Brennan, 'Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform' (2002) 80 Texas Law Review 1595

[400] Genger (n 388) 26.

[401] Genger (n 388) 24.

minds of their community members. As noted by Ilesanmi et al., some of these proverbs include '*Omi l'eniyan, e ma iba ti a san pade; de ba a san pade n'oke, a san pade n'odio* (translation: Humans are like water, and we will always meet, either upstream or downstream).'[402] Furthermore, another adage that reinforces this notion is *'Agbajo owo la fin soya*,' which literally translates to 'it is a combination of fingers that helps in hitting the chest; one finger cannot adequately lift a load to the head.' Against this background, this chapter argues that the authenticity and autochthonous nature of these proverbs signify unity, togetherness, equity, and fair play in human connections.[403] This embodies the principles and philosophy of Ubuntu and it being well-suited for resolving medical negligence disputes.

5.3 Principles of Restorative Justice in Indigenous Contexts: A Cue for Nigeria

As discussed in Chapter 3, restorative justice is a practice that is shaping how disputes are being resolved in communities, schools and workplaces.[404] Lydialye Gibson highlights that restorative justice is a concept that 'animates the American debate over reparations for slavery', driving the work of truth and reconciliation commissions following the aftermath of the apartheid and genocide in South Africa and Rwanda, respectively.[405] In Africa, the philosophy that undergirds restorative justice is Ubuntu. The essence of Ubuntu is that

[402] Ilesanmi et al. (n 382).

[403] Ibid.

[404] Response from Restorative Justice Consortium to Engaging Communities in Criminal Justice Consultation Responses (July 2009) <https://restorativejustice.org.uk/sites/default/files/resources/files/Engaging%20Communities%20in%20Criminal%20Justice%20-%20Response%20of%20the%20Restorative%20Justice%20Consortium.pdf> accessed 2 February 2025

[405] Lydialyle Gibson, 'Restorative Justice – Exploring an alternative to crime and punishment' (Harvard Magazine, July-August 2021) <www.harvardmagazine.com/2021/06/features-restorative-justice> accessed 27 May 2024.

humans do not live in isolation – human beings are humans because of other humans.

Generally, restorative justice has been practised in jurisdictions with Indigenous people, such as in New Zealand with the Maoris, in Canada with the First Nations People, and in Australia with the Aboriginals and Torres Strait Islander people.[406] Evidence has shown positive experiences of Indigenous peoples that actively took part in a restorative approach setting.[407] For example, in the New Zealand Healing After Harm program that addressed the needs of patients who suffer from surgical mesh, evidence shows that the restorative approach resonates with the relational values of the Indigenous people.'[408] Thus, there is a growing advocacy for integrating restorative justice in non-indigenous settings, especially in the West. Further, in South Africa, restorative justice through Ubuntu was relied on the reconciliation process following apartheid and in developing their legal and ethical framework.[409] Similarly, in Nigeria, disputes were settled traditionally where the family, community elders, chiefs, and traditional rulers played a vital role in resolving conflicts through reconciliation and assurance of restoration; in pre-colonial Nigeria, relying on customary laws and spiritual beliefs to achieve a resolution, aimed at maintaining social harmony within the community rather than assigning blame.[410]

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[406] Stephanie Price et al., 'A Review of Restorative Justice Programmes for First Nations Peoples in Queensland' (2023) 49(1) International Journal of Comparative and Applied Criminal Justice 1; George Mousourakis, 'Restorative Justice, Indigenous Custom and Justice Reform in New Zealand' (2015) 36(1) South Pacific Studies 1.

[407] Estelle Simard and Shannon Blight, 'Developing a Culturally Restorative Approach to Aboriginal Child and Youth Development: Transitions to Adulthood' (2011) 6(1) First Peoples Child & Family Review 28.

[408] Wailing, Wilkinson, and Marshall (n 245).

[409] Gibson (n 397); Headman S Ntlapo and Peter White, Ubuntu Justice and the South African Truth and Reconciliation Commission: An African missiological response' (2022) 8 (1) Stellenbosch Theological Journal <https://scielo.org.za/scielo.php?script=sci_arttext&pid=S2413-94672022000100013> accessed 17 January 2025.

[410] O Olusola & A Aisha, 'Traditional Rulers and Conflict Resolution: An Evaluation of Pre and Post Colonial Nigeria' (2013) 3 (21), IISTE Journals 20; Igwe O Igwe et al., 'A review of continuous relevance of the traditional methods of dispute resolution mechanism in the southeast of Nigeria' (2020) 11 (1) Beijing Law Review 34; David McQuoid-Mason, 'Could traditional dispute resolution mechanisms be the resolution to reducing the volume of litigation in pre-colonial developing countries- particularly in Africa?' (2021) 11(2) OÑATI SOCIO-LEGAL SERIES 508.

Using mental illness as an example, Ramose evinced the correlation between health, healing and Ubuntu within the African justice system. Ramose noted that mental illness is both a physical condition and a disruption to the communal harmony of the living and their ancestors; as such, the approach to healing is communal and spiritual. In essence, Ramose noted that healing involved the family of the patient, ancestors and the traditional healers (known as Ngaka). Further, he noted that in the treatment of the mentally ill, priority must be given to human dignity and communal support to ensure that the patient is cared for with compassion and without being isolated from the community. Relatedly, the hypothesis of Ramose can be adapted to resolving medical negligence disputes in Nigeria through the lens of Ubuntu.[411] Medical negligence can be likened to both an interference with the physical condition of a patient and a disruption to the harmony existing between patients and physicians- calling for a resolution mechanism that approaches both parties on healing and communal co-existence. In this case, stressing the need for collective responsibility of all stakeholders in supporting patients who have experienced medical negligence as well as medical practitioners in the healing process for those adversely affected by the incident.

Additionally, Ubuntu advocates for collective accountability as an achievable concept. Ubuntu, like the restorative justice system, underscores that everyone has the potential to affect a whole community by prioritising restitution for harm over retribution for fault. Simply put, collective accountability focuses on shared responsibility for actions, outcomes, or consequences. For example, in the event of a crisis, chaos, medical

[411] Ramose (n 381).

negligence or dispute, the entire collective takes responsibility for addressing and remedying the situation, even if not every individual directly caused the harm. While this is closely related to the tort's non-delegable duty, Ubuntu emphasises restitution and redress for harm caused without attributing blame to specific individuals. This contrasts with the tort system, which imposes strict liability on certain parties through vicarious liability. Relying on Ramose's analysis of mental illness under Ubuntu, he noted that the family of the patient and the Ngaka have a shared responsibility of caring, especially in avoiding a situation where the patient is left at the mercy of Ngaka who may expropriate the health of the victim-patient.[412]

Notably, collective accountability has associated disadvantages, such as the lack of individual accountability, scapegoating, justice inefficiency, over-generalisation and dilution of consequences. Nonetheless, by promoting dialogue, understanding, and reintegration in communities affected by an incident or dispute, Ubuntu prevents the unfair blame shaming of individuals or subgroups by constructively sharing the responsibility via reconciliation. The essence of reconciliation is to chip out systemic and repetitive issues by addressing collective and individual interests for an eventual outcome of unity. Therefore, medical negligence, much like mental illness in Ramose's context, represents a disruption of harmony in the community, and the response should not only be compensation or blame but a restoration of relationships and communal balance.

With these examples, there is a need to explore how indigenous methods of dispute

[412] Ramose (n 381) 70.

resolution can be employed within Nigeria to resolve patient safety incidents – methods that involve a collaborative approach between patients, healthcare providers, their families, and other relevant stakeholders are essential to heal from harm and prevent compounded harm. Hence, the principles of the restorative approach should be integrated into the healthcare system to work cohesively with existing alternative models that aim for similar outcomes and share the fundamentals of the restorative approach.

Given the social injustice perpetuated on patients who have been injured in healthcare due to the inability to process medical negligence claims, there is a need to re-think existing approaches to making claims.[413] An approach that puts energy into the future, not the past, should begin with who has been hurt and what their needs may be. It should also finish by giving wrongdoers a way back instead of guaranteeing them a lifetime of hardship.[414] A restorative approach should be highly considered in the Nigeria healthcare setting, especially since there are systemic issues that result in unreported patient safety incidents. As Dekker notes, 'there is a key component to learning from patient safety incidents, and it is the ability for healthcare providers and patients to be empowered to speak openly about what happened, without fear of retributive or negative consequences.'[415] This is important because of the adversarial tort system's impact on both patients and healthcare providers, potentially raising human rights concerns for the denial and the delay of medical care. The next section, based on the Ubuntu philosophy and the infusion of restorative justice, discusses how restorative justice principles can be used to resolve medical negligence

[413] Nick Hilborne, 'Medical negligence claims process can be 'inhumane experience' (2022) <www.legalfutures.co.uk/latest-news/medical-negligence-claims-process-can-be-inhumane-experience> accessed 2 February 2025.

[414] Armour (n 205).

[415] Sidney Dekker, 'Just Culture: Restoring trust and accountability in your organization' (2016) 3 (39) ProtoView Beaverton.

disputes in the Nigerian healthcare system.

5.4 ARJS in the Nigerian Healthcare System

The emergence of the Western form of dispute resolution, notably the tort system, has been utilised in the healthcare system and has long served as the dominant mechanism for dispute resolution. However, this has not proved effective. Although there are existing alternatives to the tort system, they have often not met the needs of patients within the current legal frameworks. Therefore, developing a system that considers patients' needs and justice demands in the healthcare sector will resonate with Nigerian stakeholders due to the relational and indigenous values that exist in the Nigerian culture. Evidence shows that scholars align strongly with restorative justice principles and indigenous approaches to conflict resolution.[416] Nigeria is largely an indigenous cultural state with several different ethnic groups. These groups share one common philosophy of justice, which has been termed in the African literature as 'Ubuntu.' In the Nigerian context, resolving disputes through traditional dispute mechanisms reflects the Ubuntu philosophy that prioritises dialogue, compensation, harmony and societal integration over punishments.

Unlike Western communities encourage traditional litigation mechanisms for dispute resolution. For example, the United States is known for incessant litigation suits, earning the title of the world's most litigious country with approximately forty (40) million lawsuits filed every year,[417] culminating in Former President Bush's quote that perhaps in

[416] Gerry Johnstone and Daniel W Van Ness, 'Regional Reviews' in *Handbook on restorative justice* (1st ed. Routledge, 2007).

[417] Maura Freiwald, 'Legal system abuse is rampant – What insurers can do and how reinsurers can help' (16 November 2022) <www.munichre.com/en/insights/economy/legal-system-abuse-is-rampant-what-insurers-can-do-and-how-reinsurers-can-help.html#:~:text=The%20United%20States%20is%20widely,largest%20number%20recorded%20each%20year> accessed 25 September 2024.

a kinder, gentler America, we will 'sue each other less and care for each other more.'[418] Conversely, through cultural and religious teachings, Nigeria has vehemently frowned at encouraging litigation. For example, the Yoruba ethnic tribe have a popular adage that states that *'A ò kíń lọ sí ilé ejọ́ kí á d'ọ̀ré'* which means we do not go to court and return as friends,' Essentially friendship rooted in trust is breached when disputes cannot be resolved without the intervention of the adversarial dispute resolution system. This simply discourages community members from pursuing litigation and maintains a system that emphasises amicable reconciliation. The Yorubas have relied heavily on negotiation mechanisms, which often conclude with an apology for wrongs done to an individual and community, hoping to restore the parties to where they were before the transaction. The goal is usually not just to resolve the problem but to know why the problem existed in the first place.[419]

Further, in a religious context, Nigeria is a highly religious country,[420] and religion plays a critical role in the response and behaviours of Nigerians. Onyemelukwe asserts that cultural and religious inclinations lead people 'to leave all to God' are one of the many factors responsible for the limited number of cases brought to the attention of the court,[421] Nigeria has a religious composition of about 50% Muslims, 40% Christians and 10% indigenous religions.[422] Christianity, one of Nigeria's dominant religions, preaches the

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[418] Gorge Bush, 'Remarks Accepting the Presidential Nomination at the Republican National Convention in Houston (20 August 1992) <www.presidency.ucsb.edu/documents/remarks-accepting-the-presidential-nomination-the-republican-national-convention-houston> accessed 17 December 2024.

[419] David McQuoid-Mason (n 410).

[420] Olu Fasan, 'Weber's Puzzle: Why is Nigeria so religious, yet so poor?' (23 August 2018) <https://blogs.lse.ac.uk/africaatlse/2018/08/23/webers-puzzle-why-is-nigeria-so-religious-yet-so-poor/> accessed 3 February 2025.

[421] Cheluchi Onyemelukwe, 'Medical Negligence & the Law' (2018) BeyHealth Quarterly Journal 13.

[422] Brooke Flake, 'Religion in Nigeria' International Centre for Law and Religious Studies <www.iclrs.org/blurb/nigeria-country-info/> accessed 3 February 2025.

phrase 'WWJD – What will Jesus Do?' This is in response to the biblical reference in Matthew 5:39, which states, 'if anyone slaps you on the right cheek, turn to them the other cheek also.'[423] Some religious Christians then believe that taking legal action may be contravening this bible verse or the humility and forgiving nature of Jesus Christ. On the flip side, for Muslims, the question of when to sue and obtain compensation within the framework of what may be considered haram (non-permissible acts) or halal (permissible acts) is not often straightforward.[424] Whilst some scholars have argued that suing for medical negligence and compensation is acceptable,[425] others have argued that suing for monetary compensation in financial commitment is not allowable in all instances.[426] Another author has argued that negligence and holding another for liability is permissible in Islam.[427] These issues are sometimes exacerbated when medical negligence results in death, or there is a need for an autopsy. This is because, by Islamic doctrine, the dead should be buried as soon as possible after death,[428] usually within 24 hours or a period not exceeding three days.[420][429] Therefore, the many schools of thought on what is permissible and not permissible discourage many families and individuals from taking legal actions.

[423] The Gideons International, English Standard Version (Illinois, USA, Crossway Publishing Ministry of Good News Publishers, 2013).

[424] Islamweb.net, 'Considering suing a doctor for his mistake' <www.islamweb.net/en/fatwa/87930/considering-suing-a-doctor-for-his-mistake> accessed 3 February 2025.

[425] Shaykh Abdul-Malik Sheikh, 'Suing a Doctor for Negligence' (ISLAMQA) <https://islamqa.org/hanafi/daruliftaa-birmingham/170528/suing-a-doctor-for-negligence/> accessed 3 February 2025.

[426] Abdulazeem Abozaid, 'Penalty and Compensation in Financial Commitments - A Critical Shariah Review' (2021) 38 (2) Journal of College of Sharia & Islamic Studies.

[427] Sayyed Mohammed Mushin, 'Islamic Jurisprudence on Haram Versus Harm Scenarios in Medical Confidentiality' (2024) 36 HEC Forum 291.

[428] Gardens of Peace, 'The Religious Importance of Burying Quickly' <https://gardens-of-peace.org.uk/the-religious-importance-of-burying-quickly/> accessed 3 February 2025.

[429] Zainab Quadri, 'Ten Muslim funeral traditions' (July 2015) <www.pulse.ng/articles/nigeria-religion/in-islam-10-muslim-funeral-traditions-2024080902105728507> accessed 3 February 2025; Kaltin D Weaver, 'Religions and Autopsy' (2020) <https://emedicine.medscape.com/article/1705993-overview> accessed 3 February 2025. Newrest Family Funerals, 'How Long After Death do Muslims have to be buried?' <https://newrestfunerals.co.uk/religious/muslim/how-long-after-death-do-muslims-have-to-be-buried/> accesses 3 February 2025.

Nonetheless, Islamic tenets encourage reconciliation, dialogue and forgiveness before resorting to legal actions.[430]

The above points to the receptive culture of forgiveness, openness and discussion within the African setting, which promotes reconciliation and societal reintegration. It emphasizes the unity and community required for people to thrive, as it is believed that anyone can require other's assistance at any time. This is similar to New Zealand's culture, which does not encourage suing doctors for damages.[431] Thus, with a restorative justice model that annexes the cultural way of life of the people, the model is more likely to thrive – a model that facilitates open horizontal dialogue between medical practitioners' providers and patients.

Whilst the concept of Ubuntu may be seen as a commonality within Africa with gradual migration to the West through initiatives and leadership endeavours, it also offers the opportunity to restore dignity to patients who have been undermined by the complexities of the torts system. Mokgoro recognised that westernisation has significantly undermined the traditional unity of African societies, and the use of Ubuntu has the potential to contribute value and development to African legal systems.[432] Adopting the words of Gallinetti and Sloth-Nielsen, 'the inclusion of Ubuntu-related ideologies remains relevant to the development of indigenous and locally constructed images of Africanised forms of

[430] Houda Abadi, 'Seeking an Islamic Framework towards Peacebuilding and Women's Inclusion' <https://eprints.lse.ac.uk/115252/1/Seeking_an_islamic_framework_published.pdf> 3 February 2025.

[431] KA Wallis, 'No-fault, no difference: no-fault compensation for medical injury and healthcare ethics and practice' (2017) 67 (654) British Journal of General Practice 38.

[432] Makgoro (n 385).

justice,'[433] Hence, the need to incorporate it in our healthcare system to ensure adequate justice for all parties is increasingly urgent because restorative justice is familiar and culturally receptive.

Furthermore, the African Transformative Justice Project in Nigeria, Gambia, and Ghana[434] focuses on implementing restorative justice practices that align with African cultural traditions. It includes initiatives such as victim-offender mediation and the establishment of mediation centres, which foster community legitimacy and sustainable conflict-resolution mechanisms. For example, the creation of the Africa Transformational Justice Legacy Fund (ATJLF) to ensure justice, reconciliation, peace, social cohesion, and healing after experiencing mass atrocities is making an impact within the continent. The impact of the ATJLF, according to Grace Samuel from Kishhimi Shelter and Care Foundation Nigeria, is an intervention that has helped in 'restoring at least 70 critically traumatised survivors of violence who deteriorated into full insanity due to the violence in Northeast Nigeria' to regain their sanity and bouncing back to normalcy.[435] Nigeria, with its deep-rooted history of using customary resolution mechanisms, can adopt the tenets of Ubuntu to create a patient-centred and culturally receptive framework in resolving medical negligence disputes that promotes patient trust and safety, accountability and reduces the incidences of medical negligence.

Whilst some have argued that the principles of ARJS are rooted in 'just saying sorry'

[433] Sloth-Nielsen and Gallinetti (n 397).

[434] Johnstone and Daniel (n 416) 474.

[435] African Transformational Justice Legacy Fund website <https://atjlf.org> accessed 3 February 2025.

and letting antagonists off the hook, this is debatable, considering that the underlying theme of the ARJS is to foster reconciliation and uphold ideologies of transparency and settlement. Further, the ARJS, as in the words of Gallinetti and Sloth-Nielsen, requires more of the 'transgressor than conventional Western justice models, offering many avenues for watering down or mitigating the acceptance of personal responsibility (plea bargains or the downgrading charges, agreed sentences, including fully suspended sentences on non-onerous conditions).'[436] The question is, can forgiveness accompany the pursuit of justice? Especially in the face of repetitive injuries by medical practitioners who have erred in patient safety but still do not feel sorry because they may be aided and shielded by the tort system. Whilst forgiveness saves the expense of anger, cost of hatred and animosity towards the legal system, the right to forgive must be accompanied by the acknowledgement of wrongfulness by those who perpetuate it.[437] Therefore, for forgiveness to flow from injured patients to medical practitioners, medical practitioners must be willing to admit and openly disclose their faults. After all, the medical profession is a position of trust and candour, and a relationship between patients and practitioners is essential to ensuring patients' safety in the healthcare system. Thus, there is a need for a system that promotes the 'why' by understanding why an injury has occurred and 'how' such issues can be resolved without the need for retaliation, victimisation or retribution.[438]

Whilst Africa cannot erode the influence of colonialism on its legal system, it is necessary to optimise familiar cultural dispositions in the operation of modern legal systems. This is

[436] Sloth-Nielsen and Gallinetti (n 397).

[437] Albie Sachs, 'The Strange Alchemy of Life and Law' (1st edn, Oxford University Press 2023).

[438] Ibid.

likely to quicken the trust and acceptability of such systems. Thus, culturally, the integration of restorative justice in Nigeria must consider indigenous justice systems' rich traditions and colonisation's impact on these systems. Hence there is a need to create a new, though familiar, system for dispute resolution. The concept of the Restorative justice approach chimes in with the Ubuntu philosophy. While restorative justice is a procedural and administrative approach from literature, Ubuntu is a way of life. Restorative Justice will be beneficial to Nigerian patients and effective because the Nigerian people can view it from a cultural lens. Therefore, I propose adopting the procedural and administrative relativeness of restorative justice into Ubuntu to create a unique system of resolving medical negligence and malpractice claims in healthcare settings in Nigeria.

5.5 Synergising Ubuntu, Restorative Justice and No-Fault Systems as a Model for Resolving Medical Negligence Disputes in Nigeria

Although forgiveness and reconciliation are necessary in dispute resolution, as previously discussed, their adequacy and sufficiency have been questioned in healthcare. Some authors have argued that forgiveness and reconciliation in the absence of more may be difficult, as merely forgiving a transgressor may be insufficient in meeting the patients' expectations.[439] Thus, will restorative justice with Ubuntu as a stand-alone model be adequate in meeting patients' expectations in resolving medical negligence disputes in Nigeria?

The socio-economic challenges faced by many Nigerians who are at the behest of an

[439] Yohsuke Ohtsubo et. al, 'Costly apologies communicate conciliatory intention: an fMRI study on forgiveness in response to costly apologies' (2018) 39(2) Evolution and Human Behaviour Journal 249.

economically crippling economy[440] may find a restorative approach merely insufficient in meeting patients' needs in healthcare settings. This is because Nigeria is one of the world's poverty capitals, with people (patients) living in extreme poverty.[441] Thus, an incident of medical negligence without providing compensation for loss may be unwelcoming. This may be due to the financial expenses of obtaining care in the first place or other financial implications, such as loss of earnings, after receiving care.[442] Therefore, will integrating a no-fault system allay these challenges?

Undisputedly, with Nigeria's vast cultural diversity, the Nigerian legal system can thrive through the integration of a model based on Ubuntu and restorative justice. This is because one of the cornerstones of Nigerian society is a set of ideals and values that bind people together, fostering a shared responsibility for resolving disputes. Nonetheless, the need for a model like the no-fault system may resonate with the economic realities of Nigerians. Therefore, this section discusses the element of togetherness, reminiscent of Ubuntu, the equitable compensation provided by the no-fault system, which is further advanced by restorative justice, as an alternative model to the tort system in Nigeria.

Whilst the restorative justice system facilitates reconciliation, community rebuilding, and offender rehabilitation, providing social and emotional restoration to (injured) parties, the no-fault system is an administrative, financial scheme that mitigates the economic impact

[440] Olisa Chukwumah, Ben Shemang and Isaac Kaledzi, 'Nigerians struggle to make ends meet amid economic crisis' (2024), available at <www.dw.com/en/nigerians-struggle-to-make-ends-meet-amid-economic-crisis/a-69656094> accessed 10 February 2025.
[441] The World Bank estimated the Nigerian poverty rate to reach 38.9% in 2023, with over 87 million Nigerians living below the poverty line. The World Bank in Nigeria www.worldbank.org/en/country/nigeria/overview#3> accessed 10 February 2025.

[442] David M Studdert et al., 'Can the United States Afford a 'No-Fault' System of Compensation for Medical Injury?' (1997) 60(2) Law and Contemporary Problems 1.

caused by medical injuries to patients (see Chapter 4). Unlike the traditional adversarial system, which encourages a win-lose approach, as discussed in Chapter 2, the no-fault system diffuses the risk of being sued for negligence but with the added advantage of assured compensation within the framework of existing statutes. This relieves patients and medical practitioners of the stress, costs, inconvenience and uncertainty of pursuing claims at different cadres of the traditional adversarial systems. Whilst practitioners are not exonerated from being regulated by medical regulatory bodies, it gives the patients a soft landing to get [443]'justice' in due time for the consequences of a 'failed' health sector.

Endemic to the tort system, in both social and legal contexts, a no-fault system represents a model that does not require the establishment of blame or fault on the part of parties to receive compensation. However, in some cases, there may be a need to show a causal link between the patient's injury and the medical intervention provided. Further, under a restorative justice approach or a no-fault system, responsibility is viewed as collective or systemic rather than being attributed to a specific individual. In a no-fault system, there is no requirement for proof of fault, which allows for a milder adversarial process and ensures the harmonious resolution of conflicts void of individuality. By so doing, these systems acknowledge that specific actions or harms can be because of a broader social, cultural, or systemic influence requiring the equal participation of individuals, organizations, or communities.[444]

[443] Kirsten Armstrong and Daniel Tess, 'Fault versus No Fault- Reviewing the International Evidence' (Presented to the Institute of Actuaries of Australia 16th General Insurance Seminar, November 2008).

[444] Schoeman (n 380) 291.

On the other hand, Ubuntu, as a philosophical way of life, deeply prioritises cross-sectional connectedness, mutual respect, and the collective well-being of every individual in the society. The phrase 'I am because we are' identifies Ubuntu at its core.[445] Thus, in ano-fault system, Ubuntu is mirrored in the idea that the focus is not on blaming individuals for harm caused but rather on finding solutions that restore relationships, promote healing, and uphold community values. Some authors have argued that the no-fault system is a response to systemic issues battling healthcare.[446] Nigeria currently operates a systemically deficient healthcare system as discussed in Chapter 1. Therefore, a no-fault system is likely to meet patients' claims which may sometimes not be caused by the individual error of a medical practitioner. Thus, incorporating the no-fault system means shifting from individualism to collective responsibility, as well as the importance of community solidarity and shared well-being and value.[447]

Further, in the context of restorative justice, the no-fault system, in conjunction with Ubuntu, shifts from retributive to restorative measures. Restorative justice, as a framework, seeks to repair harm by addressing the needs of all parties involved, including the victim, the offender, and the broader community. Instead of focusing on punishment, it aims to restore balance and facilitate healing.[448] Moreover, it prioritises healing, apology, mutual understanding, inclusivity, dialogue, and collective accountability.

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[445] JS Chowdhury et al., 'Ubuntu Philosophy: 'I Am Because We Are' – A Road to 'Individualism' to Global Solidarity' in Haris Abd Wahab et al. (eds) Handbook of Research on the Impact of COVID-19 on Marginalized Populations and Support for the Future (IGI Global 2021).

[446] Iyioha (n 12).

[447] Ramose (n 381).

[448] Howard Zehr, 'The Little Book of Restorative Justice' (Intercourse PA: Good Books, 2002); Gerry Johnstone. 'Restorative Justice: Ideas, Values, Debates' (New York: Routledge, 2002).

This synergised model prioritises healing, emotionally and financially. The emphasis is on meeting the needs of patients affected by injury caused while receiving care rather than assigning blame or seeking punitive measures. This promotes a sense of closure and healing for all parties. Evidence has shown that patients want closure by having access to information leading to their injuries and want practitioners to take accountability for same, and in most cases, accompanied with compensation.[449] Thus, the best option is to have a no-fault system, Ubuntu and restorative justice principles because they prioritise collective healing, restitution, and the preservation of relationships over punitive outcomes.[450]

As rightly posed by Radin,[451] Tort law serves as an economic tool for cost-benefit analysis for claimants, equating the value of harm caused to the financial compensation awarded as damages. This makes tort prioritize monetary values over the mental and emotional realities of patients (which cannot be denoted in figures), which is a challenge faced by those who experience medical negligence. In contrast, Ubuntu, restorative justice, and no-fault systems promote inclusivity and dialogue, an appropriate balance. Communication between parties is essential to restorative justice because it fosters reconciliation and prevents conflict. Victims, offenders, and communities must work together to create and preserve inclusivity and communication for restorative justice.

This partnership restores productive connections and rekindles trust without

[449] A Simanowitz, 'Australia needs an organisation for victims of Medical Accidents' (1995) 311 BMJ 194; See also C. Vincent, M. Young and A. Phillips, 'Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action' (1994) 343 The Lancet 1609; M A Jones, 'Medical Negligence' (3rd ed., Sweet & Maxwell, 2003).

[450] Schoeman (n 380).

[451] Radin p. 57

compromising personal well-being or belonging. These approaches collectively repair harm and foster dialogue instead of assigning blame. The tort system has suffered backlash because the road map to obtaining justice is often not as straightforward as it seems. Conversely, the no-fault system is gradually becoming influential in various jurisdictions because it simplifies the dispute resolution and compensation process.

For justice reform, especially in medical negligence cases, the intersection of the no-fault system and restorative justice comes as a much-needed relevance to the discourse as either of these systems advocates for collaborative processes and prioritises the needs of victims while promoting accountability among offenders. What is noteworthy is that their integration in communities can cultivate environments that not only address harm but also enhance social cohesion and resilience. This introduction sets the stage for a deeper exploration of how the no-fault system and restorative justice contribute to the evolving landscape of justice, with a specific focus on the philosophical underpinnings of Ubuntu and its implications for society at large.

Ubuntu and restorative justice stress accountability not as a form of punishment but as a means of recognizing harm and working toward its resolution. The no-fault system encourages this by ensuring that parties focus more on solutions and compensation than guilt and blame.[452] The assimilation of this system considers cultural values and beliefs and is likely to influence the Western system, which is not autochthonous.

Ultimately, both Ubuntu and restorative justice rebuild broken or lost relationships that

[452] Charles Villa-Vicencio and Fanie Du Toit (eds), 'Truth and Reconciliation in South Africa: 10 Years On' (Cape Town, Institute for Justice and Reconciliation 2006).

may have been strained by conflict or harm and maintain thriving societies free from individual stigmatisations. In conjunction, a no-fault system facilitates these approaches by holistic removal of antagonism at all concerned levels and by creating structures where the goal of restoring well-being can be realised. Ubuntu is a philosophy that emphasises human dignity, compassion, and communalism, providing an African-centred perspective aligned with no-fault compensation and restorative justice. An integrated strategy can address the shortcomings of Nigeria's current medico-legal system by fostering communication, accountability, and system-wide reforms. This will ensure that patients receive timely and fair compensation while upholding accountability among healthcare providers. Nigerians deserve a system that encourages participation, reparation, reintegration and compensation. That is the model proposed.

5.6 Legislative Reform and Actionable Plan

Nigeria continues to suffer not from the plethora of laws but from the lack of adequate enforceability and implementation.[453] Thus, there is a need to establish legislation and an administrative outfit to ensure this model is pursued to the latter. Therefore, this thesis proposes the establishment of the Nigerian Medical Accidents Accountability and Compensations Act (NMAACA).

Following this, an administrative organ should be created named the Nigerian Medical Accidents Accountability and Compensations Commission (NMAACCO), which will support the implementation of the restorative justice, no-fault models and Ubuntu models.

[453] IK Ukeje et al, 'Governance approach to policy implementation challenges and sustainable developments: Conceptual implications from the Nigerian case of TraderMoni empowerment scheme' (2023) 4 (2) African Social Science and Humanities Journal 61.

They will also be the first point of call for incidences of medical negligence. NMAACA will serve as a specialised administrative body that ensures fair, transparent and accessible procedures for facilitating the resolution of medical negligence claims.

The function of NMAACCO will include sensitization campaigns and public and stakeholder engagement. The body will also be charged with case assessments to evaluate claims reported to it. Importantly, to generate data on the incidences of medical negligence, NMAACCO will be tasked with monitoring and systemic learning to analyse trends and recommend policies that can enhance trust and patient safety within the health system. To ensure that Ubuntu is adequately adapted, it is proposed that the administration of NMAACCO should consist of medical practitioners, patient advocacy representatives, patient groups, government and policymakers, legal experts, and appointments of traditional rulers and religious leaders.

5.7 Possible Challenges with the Proposed Model

This thesis recognises that no legal system is perfect. Thus, there is a need to discuss some of the probable challenges this model will likely encounter in its implementation. There is a need to establish the type of no-fault scheme to be applied in Nigeria; developing a threshold can be challenging given the systemic issues with the existing health system. Another challenge is the funding of the model to be applicable. Funding is likely to pose significant challenges in meeting the no-fault scheme policy as a viable model for addressing the inadequacies of the torts system in Nigeria. Establishing and sustaining a sustainable compensation fund is difficult in Nigeria due to the country's current healthcare budget constraints.

Whilst New Zealand and other no-fault models have been funded primarily by the state and, in some instances, insurance premiums, funding the Nigerian scheme may suffer if it is based on insurance. Nigerians have apathy towards insurance,[454] and the funding for the administration of the no-fault model becomes a challenge. With unstable economic policies, there is a need to understand the Nigeria's socio-economic climate to ensure the model's success.[455] Therefore, public and private insurance providers may need to develop a public-private partnership to develop a sustainable financial model to fund the no-fault system.

Another drawback of exploring the No-Fault model in Nigeria is the likelihood of attracting frivolous complaints if the negligence threshold is removed. According to Studdert et al. using the United States as an example noted that critics of the no-fault system argue that the system's design would necessitate a much larger pool of not only patients but also victims of medical negligence but of any medical care.[456] Whilst this may meet reason, some authors have countered this point.[457] Nonetheless, there is a need to ensure that frivolous claims do not impede the efficiency of the system. This is possible where there is a clear criterion for determining eligibility for compensation.

[454] Africa Economic Research Consortium, 'Why Nigerians avoid healthcare insurance -Researchers' (10 October 2024) https://aercafrica.org/why-nigerians-avoid-health-insurance-researchers/#:~:text=Research%20experts%20in%20Nigeria%20on,limited%20treatment%20options%2C%20among%20others accessed 2 January 2025.

[455] Ogunde, 'Is the Nigerian economy capitalist, socialist or mixed?' (2019) <www.stears.co/article/is-the-nigerian-economy-capitalist-socialist-or-mixed/> accessed 9 January 2025.

[456] Studdert et al. (n 444).

[457] Bismark et al. (n 368).

Another possible challenge is a pushback from medical practitioners who may view the system as a decoy for punitive measures to be taken against them later in the future or by regulatory agencies, especially through the open disclosure forums. Thus, there is a need to reassure health practitioners of the win-win possibilities the model seeks to provide.

Corruption is another staggering challenge that will likely affect the proposed models' efficient operation. The Nigerian society has been permeated with corruption from leadership to followership. The misappropriation of funds and bribery prevalent in regulatory bodies possess significant barriers to implementation.[458] The dangers of this are the possibility of diversion of funds intended to sustain the model to frivolous activities or ventures.

Without reservation, I admit that the no-fault system as a legal system is not independently perfect. Therefore, implementing a restorative justice system embedded with a no-fat system, given Nigeria's cultural nuances and legal regime is an invaluable recommendation. It will be a breath of fresh air for not just patients but medical practitioners and the community. The legal system should aim to be fair to all parties and not perfect to just one party. This is the idea of the embedded systems of restorative justice and a no-fault system. Adopting the phrase of Richard Epstein, 'to find fault is easy, to find no fault is fair.'[459]

[458] RO Anazodo et al, 'Leadership, Corruption and Governance in Nigeria: Issues and Categorical Imperatives' (2015) 9(2) African Research Review 42.

[459] RJ Epstein, 'To find fault is easy, to find no-fault is fair' (2023) 10 (1) Future Health Journal 85.

5.8 Conclusion

In Nigeria, anecdotal evidence confirms that under-litigation in medical malpractice claims has become a clear phenomenon. The litigation apathy in medical negligence claims in Nigeria, and other parts of the world, can be linked to the rigour, cost and unpredictability of the tort system in delivering justice and due compensation. Systemic issues in Nigeria emphasise the necessity for a shift from adversarial to collaborative and consensus-seeking solutions in the country's healthcare system. These issues have further exacerbated the delays endemic to the tort system.

For Nigeria's medico-legal system, a model that integrates Ubuntu, restorative justice, and no-fault compensation offers a revolutionary opportunity. By emphasising equitable compensation rather than legal formalities, prioritising systemic learning over blame, and favouring reconciliation over retaliation, Nigeria can establish a sustainable and culturally relevant framework for addressing medical negligence claims. This chapter proposes a culturally resonant, efficient and equitable model for resolving medical negligence disputes in Nigeria. This model fosters healing by reducing adversarial litigation and ensuring fair compensation to patients who have suffered from medical negligence.

There is a revolutionary chance to settle medical malpractice cases in Nigeria through an integrated strategy that uses of Ubuntu, restorative justice, and no-fault compensation. To facilitate this shift, policymakers must ensure that financial plans, institutional bolstering, and legislative reforms are in place.

CONCLUSION

Chapter One of this thesis provides background on the systemic and individual challenges faced by the Nigerian health system. It examines these issues as the foundation of recurring medical negligence cases in Nigeria and calls for a complete overhaul of the system.

Furthermore, Chapter Two examines the current tort system and the legal avenues available to those seeking justice for medical negligence. It investigates the complexities of establishing a claim under tort law while highlighting the physical and emotional suffering that patients endure within this framework, in addition to the delays that plague the system. Another concern is that when patients pursue justice for medical negligence through the tort system, there is a lingering penalty cost rule, where claimants may be liable for the legal fees of doctors if they lose a case against a medical practitioner, making the tort system unattractive.[460]

Additionally, Chapter Three explores the restorative justice approach as a better alternative for meeting patient's emotional and psychological needs by providing an accurate picture of the events leading to their experience of negligence. It presents a comprehensive analysis of justice within the boundaries of medical law. It answers the question of whether patients have attained justice within the existing legal framework for seeking redress in medical negligence cases. Additionally, it considers whether it is worth

[460] Ray Nickson and Alice Niekerk, 'Restorative Justice in healthcare settings: better outcomes for patients and medical professionals' (2024) 49 (2) Alternative Law Journal 82.

erecting a structure of restorative justice to shield and secure the fate of patients who have experienced medical negligence in the healthcare sector. Therefore, it examines successful restorative justice practices in New Zealand and the United States, along with the administration of these programs. An example is a restorative approach used to address surgical mesh in New Zealand.[461] It discusses this approach as having the potential to measure safety towards preventing initial harm and address compounded harm through a collaborative design amongst all parties that will aim to reconcile parties through dialogue, compensation, apology, and healing for the parties involved. Entrenching advocacy is integral to afford patients the opportunity to express their experiences and encounters freely and note points to help improve the healthcare system and the resolution models available. And the need to ensure[462] a culture of openness in which lessons can be learned from things that go wrong, to help take steps that limit their re-occurrence.

While many patients appreciate a restorative approach in settling their medical negligence disputes, others prefer compensation without the burden of proving negligence. Therefore, Chapter Four discusses the no-fault system as an alternative to the tort system. It explores a comparative analysis of the different variations of the no-fault system in New Zealand, Sweden, Denmark, and the United States. As earlier noted, this research does not solely argue for the full integration of the no-fault system into the Nigerian context. However, it purports that specific characteristics should be situated within the Nigerian

[461] Wailing et al. (n 162).

[462] A Merry and W Brookbanks, 'Negligence, Recklessness and blame', in Merry and McCall Smith's Errors, Medicine and the Law (2017) Cambridge University Press (Cambridge Bioethics and Law) 183.

context, considering the complexities and cultural nuances. For example, restorative alternative techniques focused on healing and apology.

Consequently, Chapter Five recognises that the tort system, in its operation, does not guarantee the provision of redress to patients within the Nigerian context. Therefore, there is a need to abolish the fault system and the adoption of a system that addresses the adverse impacts of the delay of justice on patients and physicians. Hence, Chapter Five develops an integrated model of restorative justice and a no-fault system incorporating the principles of Ubuntu. This chapter advocates for Ubuntu as a recognised and culturally appreciated form of patient-centred dispute resolution to foster restorative approaches and a no-fault system in meeting the justice needs of patients. Adopting the famous dictum of Lord Hewart CJ in the case of *Rex v. Sussex Justices,* where he stated that 'justice must not only be done but must also be seen to be done,'[454] this chapter advocates an integrated model of Ubuntu, no-fault and restorative justice to proffer justice to patients in truth and deed. This research also suggests that future research should focus on patient and medical practitioners' satisfaction with the adversarial system to determine whether the tort system in Nigeria can be improved. This is necessary to inform policy on administrative mechanisms and alternatives to litigation that can be adopted to ensure speedy and efficient resolution while at the same time minimizing harm to both parties.

Finally, analogous to the American dream, my Nigerian dream is for the average Nigerian to have access to medical care that embodies trust and prioritises patients' needs. Furthermore, this dream incorporates the idea that patients do not become losers in their quest to seek justice expeditiously in the event of medical negligence.

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