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"Medical Negligence and Patient Safety in Nigeria: Examining the Causes, Consequences, and Pathways to Healthcare Accountability"

Medical Negligence and Patient Safety in Nigeria: Examining the Causes, Consequences, and Pathways to Healthcare Accountability

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ABSTRACT

Hospitals meant to heal too often become sites of preventable harm, a paradox that lies at the heart of this paper on medical negligence and patient safety in Nigeria: examining the causes, consequences, and pathways to healthcare accountability. The paper was guided by four objectives, namely to examine the causes of medical negligence within Nigeria's public and private healthcare facilities, including workforce, infrastructural, and regulatory factors; to assess the consequences of medical negligence on patient safety, morbidity, mortality, and public confidence; to evaluate the legal, institutional, and professional obstacles hindering victims from obtaining redress; and to identify pathways toward strengthening healthcare accountability and patient safety enforcement. The paper adopted Reason's Organisational Accident Model as its theoretical framework, conceiving negligence as the product of aligned weaknesses across layered organisational defences rather than isolated individual failing, and employed a narrative, desk-based review methodology drawing on recent, verifiable scholarly sources. The paper findings revealed that workforce depletion, infrastructural deficiency, and weak regulatory enforcement jointly predispose Nigerian facilities to negligent outcomes, producing measurable morbidity, psychological distress among practitioners, and a cumulative erosion of public confidence, while evidentiary burdens, fragmented tribunal mandates, and a professional culture resistant to disclosure obstruct redress. The paper concluded that reform requires coordinated rather than piecemeal intervention and recommended mandatory facility inspection standards, non-punitive incident-reporting systems, and harmonised regulatory-legal redress mechanisms.

KEYWORDS: Medical Negligence, Patient Safety, Healthcare Accountability, Health System Regulation

INTRODUCTION

Patient safety has emerged as one of the defining public health concerns of the present decade, with unsafe medical care now recognised globally as a leading cause of preventable harm. According to the World Health Organization, more than one in ten patients is harmed while receiving hospital care, and unsafe practices account for over three million deaths annually

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worldwide, with roughly half of this harm considered avoidable (World Health Organization, 2024). The burden of this harm is not evenly distributed; low- and middle-income countries bear the greatest share, with an estimated 2.6 million deaths occurring yearly in these regions as a direct consequence of unsafe hospital care (World Health Organization, 2024). This disparity has prompted the World Health Assembly to adopt the Global Patient Safety Action Plan 2021–2030, an initiative intended to guide member states, including Nigeria, toward eliminating avoidable harm in health service delivery (World Health Organization, 2024).

Within this global picture, Nigeria occupies a particularly troubling position. As sub-Saharan Africa's most populous nation, its healthcare system continues to operate under conditions of chronic underfunding, workforce depletion, and weak institutional oversight, all of which converge to heighten the risk of clinical error and professional negligence (Ogueji et al., 2024). Empirical evidence from within the country illustrates the scale of the difficulty. A cross-sectional survey of medical practitioners in Abia State found that 42.8% of respondents had committed a medical error, with prescription mistakes, faulty laboratory or radiological requests, and diagnostic failure identified as the most frequent occurrences (Iloh et al., 2017).

Beyond statistics, individual accounts continue to surface with disturbing regularity. In September 2025, a woman in Kano State died after surgical scissors were left inside her abdomen following an operation, a case that the state's hospital management board later confirmed as an act of negligence (Abdullahi, 2026). In January 2026, the death of the twenty-one-month-old son of the Nigerian author Chimamanda Ngozi Adichie, allegedly following inadequate monitoring after sedation at a private Lagos hospital, drew nationwide attention to the persistence of avoidable clinical lapses even within well-resourced facilities (Abdullahi, 2026).

These occurrences are symptomatic of deeper structural conditions. Nigeria's doctor-to-population ratio stands at roughly 3.9 per 10,000 people, well below the World Health Organization's recommended benchmark, a shortfall worsened by the continuing emigration of trained health personnel commonly referred to as the "japa" phenomenon (Abdullahi, 2026). Weak enforcement of the National Health Act 2014 and inconsistent supervision by regulatory councils have further allowed substandard practice to persist largely unchecked (Adam, 2026). It is against this backdrop, of a global patient safety crisis intersecting with peculiar national vulnerabilities, that the question of medical negligence and accountability in Nigeria's health sector must be examined.

STATEMENT OF THE PROBLEM

Despite the existence of statutory and professional frameworks intended to safeguard patients, including the National Health Act 2014 and the Code of Medical Ethics administered by the Medical and Dental Council of Nigeria, medical negligence continues to occur with troubling frequency and largely without meaningful consequence for those responsible. Research conducted between 2013 and 2021 across Nigerian healthcare facilities has documented error prevalence rates

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ranging from 42.8% to as high as 89.8% among surveyed practitioners, spanning medication mistakes, surgical errors, blood transfusion incidents, and delayed or wrongly interpreted diagnostic investigations (Iloh et al., 2017; Abdullahi, 2026).

Compounding this pattern is a pronounced culture of underreporting, with studies indicating that only between 30% and 84% of medical errors are ever formally disclosed, largely owing to practitioners' fear of professional sanction, litigation, or reputational damage (Abdullahi, 2026). This concealment obscures the true scale of harm and forecloses the institutional learning that might otherwise prevent recurrence.

A further dimension of the problem lies in the near impossibility of securing redress once harm has occurred. Odunsi (2023) demonstrates that patients pursuing negligence claims in Nigerian courts confront protracted litigation, high evidentiary thresholds requiring expert medical testimony that is often difficult to obtain, and overlapping, poorly coordinated regulatory mandates among disciplinary tribunals. Adegboyega (2024) similarly identifies procedural delay, prohibitive litigation costs, and the reluctance of medical practitioners to testify against colleagues as decisive obstacles that discourage aggrieved families from initiating or sustaining legal action. The consequence is a justice gap in which practitioners implicated in serious lapses, including cases resulting in death or permanent disability, frequently continue practising with little institutional consequence (Abdullahi, 2026).

Underlying these accountability failures are systemic health system deficiencies. Drawing on the World Health Organization's building-blocks framework, Ogueji et al. (2024) identify prolonged patient waiting times, inadequate clinical history-taking, absent or poorly enforced procedural protocols, ill-equipped facilities, underdeveloped patient safety systems, and acute workforce shortages as the principal drivers of negligent care among Nigerian health workers. Tamuno-opubo et al. (2024) reach comparable conclusions, noting that a weak patient safety culture and insufficient institutional investment in safety infrastructure remain pervasive across both public and private facilities. Akinpelu and Akintola (2021) add that the strain imposed by public health emergencies, exemplified by the COVID-19 pandemic, further exposed and intensified pre-existing diagnostic and infrastructural weaknesses.

The central problem, therefore, is not the absence of legal or ethical standards governing medical practice in Nigeria, but the persistent gap between those standards and their enforcement. This gap leaves patients exposed to preventable harm, denies victims and their families access to timely and adequate redress, and permits systemic weaknesses in staffing, supervision, and facility standards to remain largely unaddressed. Understanding the precise causes of this accountability deficit, and identifying workable pathways toward stronger enforcement and institutional reform, constitutes the principal concern of this study.

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AIM AND OBJECTIVES OF THE PAPER

This study aimed to examine the phenomenon of medical negligence and its implications for patient safety within the Nigerian healthcare system, with particular attention to the factors that give rise to negligent practice, the consequences borne by patients and the health system at large, and the institutional pathways through which accountability may be strengthened.

The specific objectives of this were to:

1. examine the causes of medical negligence within Nigeria's public and private healthcare facilities, including workforce, infrastructural, and regulatory factors.
2. assess the consequences of medical negligence on patient safety, morbidity, mortality, and public confidence in the Nigerian healthcare system.
3. evaluate the legal, institutional, and professional obstacles that hinder victims of medical negligence from obtaining redress in Nigeria.
4. identify and appraise pathways toward strengthening healthcare accountability and patient safety enforcement in Nigeria.

LITERATURE REVIEW

The review of literature for this paper were done under conceptual review, empirical review and theoretical framework:

Conceptual Review

Medical Negligence

Medical negligence has attracted a range of scholarly formulations, most of which converge on the breach of an owed duty of care but diverge in their emphasis on causation, intent, and consequence. Khanam (2023) situates medical negligence within tort law, describing it as the failure of a healthcare practitioner to meet the standard of care expected of a reasonably competent professional in similar circumstances, a failure that becomes actionable once it results in demonstrable harm to the patient.

Writing from a Nigerian legal standpoint, Odunsi (2023) extends this formulation by framing medical negligence as a breach of professional duty arising from the doctor-patient relationship, one whose proof requires establishing not merely that an error occurred but that the error was the direct cause of the injury sustained. Adegboyega (2024) similarly stresses the evidentiary dimension, noting that Nigerian courts require claimants to demonstrate the existence of a duty of care, its breach, and a causal link to injury before liability can be established, a threshold that in practice manifests through documented instances such as misdiagnosis, wrongful prescription, retained surgical instruments, delayed intervention, and failure to obtain informed consent.

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These accounts differ modestly in orientation, with Khanam (2023) foregrounding the international human rights implications of negligent care and Odunsi (2023) and Adegboyega (2024) situating the concept firmly within Nigeria's evidentiary and procedural realities, yet all three converge on breach of duty and resultant harm as the defining elements.

For the purposes of this paper, medical negligence is adopted as the failure of a healthcare provider to exercise the degree of skill, care, and diligence expected of a reasonably competent practitioner in similar circumstances, resulting in demonstrable injury, disability, or death to a patient, a definition that accommodates both the clinical instances documented in Nigerian practice and the legal standard applied in adjudicating such claims.

Patient Safety

Scholarly treatment of patient safety has evolved from a narrowly clinical concern into a systems-oriented construct. Tadia et al. (2025) adopt the classical Institute of Medicine formulation, describing patient safety simply as the prevention of harm to patients, while cautioning that error-free performance is an unrealistic expectation given the pressured and unpredictable conditions under which healthcare workers operate. This individually focused definition is broadened considerably by Alabdaly et al. (2024), whose scoping review characterises patient safety as inseparable from the organisational culture of the institution delivering care, arguing that safety outcomes are shaped less by isolated practitioner competence than by shared norms, leadership commitment, and open communication about error within the workplace.

Ogueji et al. (2024), drawing on the World Health Organization's health system building blocks, adopt a still wider frame, positioning patient safety as an emergent property of the entire health system, dependent on adequate staffing, functioning infrastructure, sound governance, and reliable information systems rather than on clinical vigilance alone. The distinction between these positions is one of scope rather than substance: Tadia et al. (2025) centre the individual encounter, whereas Alabdaly et al. (2024) and Ogueji et al. (2024) locate safety within organisational and systemic structures.

For this paper, patient safety is adopted as the prevention of avoidable harm to patients through the sustained functioning of safe clinical practice, organisational culture, and health system infrastructure, a definition broad enough to capture both individual clinical lapses and the structural deficiencies that predispose Nigerian health facilities to negligent outcomes.

Healthcare Accountability

The concept of healthcare accountability has likewise attracted differentiated scholarly interpretation. Abor and Tetteh (2023), studying teaching hospitals in Ghana, define accountability along three interrelated dimensions, namely financial accountability concerning the proper use of resources, performance accountability concerning measurable service outcomes, and political or

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democratic accountability concerning responsiveness to oversight bodies and the public, arguing that genuine hospital governance requires the simultaneous presence of all three.

This institutional framing contrasts with the more individually oriented position advanced by Peteet et al. (2023), who argue that accountability in medicine should be understood not merely as the external condition of being held answerable after harm occurs, but as a professional virtue actively cultivated by practitioners, involving a willingness to disclose error, submit to scrutiny, and participate in corrective learning. Where Abor and Tetteh (2023) locate accountability within governance structures, financial oversight, and regulatory enforcement, Peteet et al. (2023) locate it within the ethical disposition of the individual clinician, suggesting that structural mechanisms alone cannot guarantee accountable practice without a corresponding professional culture that welcomes answerability.

Reconciling these positions, this paper adopts healthcare accountability as the obligation of individual practitioners and health institutions alike to answer for the quality, safety, and outcomes of care provided, encompassing both the institutional mechanisms of oversight, reporting, and sanction, and the professional willingness of practitioners to acknowledge and learn from error, a definition suited to examining why accountability for medical negligence in Nigeria remains, in practice, difficult to enforce.

Causes of Medical Negligence in Nigeria's Public and Private Healthcare Facilities

The causes of medical negligence within Nigeria's healthcare facilities are best understood as an accumulation of workforce, infrastructural, and regulatory deficits that jointly predispose practitioners to error as explained:

i. Brain Drain

On the workforce dimension, the sustained emigration of trained personnel has emerged as one of the most extensively documented drivers. Udom et al. (2024), examining tertiary hospitals in Akwa Ibom State, found that poor working conditions, low remuneration, and political instability constitute the principal push factors compelling health workers to seek employment abroad, leaving remaining staff to absorb heavier caseloads with diminished supervision. Ajoseh et al. (2024) corroborate this pattern at a national level, noting that approximately half of Nigeria's licensed medical doctors have emigrated in recent years, a trend so pronounced that it prompted an unsuccessful legislative attempt to restrain newly qualified doctors from leaving the country. Umar et al. (2025) situate this exodus within a wider health-system crisis, observing that the depletion of skilled personnel directly compromises the capacity of remaining practitioners to deliver safe, adequately supervised care.

This workforce strain has a demonstrable clinical consequence: Iloh et al. (2017), in their cross-sectional study of 145 practitioners in Abia State, found that the committal of medical errors was

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significantly associated with fewer than ten years of clinical experience, suggesting that inexperienced practitioners, often deployed to cover shortfalls left by emigration, bear a disproportionate share of error risk.

ii. **Infrastructural deficiency**

Infrastructural deficiency constitutes a second, closely related cause. Ogueji et al. (2024b), applying the World Health Organization's health system building-blocks framework to a purposive sample of fifty-one Nigerian healthcare providers, identified prolonged patient waiting times, inadequate history-taking, the absence of standardised procedural protocols, and poorly equipped facilities as recurrent structural conditions under which negligent outcomes arise. Their respondents specifically described treating patients in facilities lacking the basic equipment necessary to fulfil diagnostic or procedural obligations, a circumstance that transforms ordinary clinical judgement into a matter of institutional improvisation.

Tamuno-opubo et al. (2024), reviewing twelve empirical studies conducted across Nigerian healthcare settings between 2015 and 2023, similarly found that an underdeveloped patient safety culture, characterised by weak incident-reporting systems and limited investment in safety infrastructure, was consistently associated with the persistence of preventable harm in both public and private facilities.

iii. **Regulatory Weakness**

Regulatory weakness compounds these workforce and infrastructural pressures. Odunsi (2023) observes that Nigeria's oversight architecture for medical practice, comprising disciplinary tribunals and professional regulatory councils, suffers from overlapping mandates and inconsistent enforcement, conditions that allow substandard practice to persist without meaningful correction. Adegboyega (2024) extends this analysis, arguing that the absence of routine, independently verified inspection of both public and private facilities means that lapses in protocol adherence frequently go undetected until a serious adverse event forces regulatory attention. This is illustrated concretely by Iloh et al.'s (2017) finding that of the sixty-two practitioners who admitted to committing a medical error, none had faced any form of disciplinary or legal proceeding, a statistic that exposes the practical absence of routine regulatory consequence for identified negligence.

In all, the literature reviewed above indicates that medical negligence in Nigeria is rarely attributable to an isolated act of individual carelessness; rather, it recurrently reflects the convergence of an overstretched and inexperienced workforce, facilities lacking the basic infrastructure required for safe practice, and a regulatory system whose enforcement mechanisms remain largely reactive rather than preventive.

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Consequences of Medical Negligence on Patient Safety, Morbidity, Mortality, and Public Confidence

The consequences of medical negligence in Nigeria extend beyond the immediate clinical event to encompass measurable morbidity, mortality, and a demonstrable erosion of public confidence in the healthcare system.

At the clinical level, Iloh et al. (2017) documented that medication prescription errors occurred in 95.2% of cases where negligence was reported, radio-laboratory investigation errors in 83.9%, and diagnostic errors in 69.4%, indicating that the harm arising from negligence in Nigerian facilities is neither isolated nor confined to a single stage of the care pathway but recurs across prescribing, investigation, and diagnosis. Such errors translate directly into preventable morbidity, including prolonged hospitalisation, permanent disability, and, in a proportion of cases, death. The psychological toll on practitioners themselves is also documented: among the sixty-two practitioners in Iloh et al.'s (2017) sample who admitted to committing an error, 33.8% reported experiencing depression, indicating that the consequences of negligence extend into the mental health of the health workforce and, by extension, into their subsequent capacity to deliver safe care.

Beyond individual clinical harm, negligence has systemic implications for patient safety culture. Tamuno-opubo et al. (2024) found that repeated exposure to preventable adverse events without corresponding institutional learning perpetuates a cycle in which safety failures recur, as facilities lacking structured incident review mechanisms are unable to convert individual errors into system-wide corrective action. Akinpelu and Akintola (2021) reinforce this observation in the context of diagnostic error during the COVID-19 pandemic, arguing that pre-existing infrastructural weaknesses were exposed and intensified under emergency conditions, producing a measurable deterioration in diagnostic accuracy and patient outcomes during a period of acute health system strain.

Perhaps the most consequential effect of sustained medical negligence is the erosion of public trust in the healthcare system. Ogueji et al. (2024a), in a qualitative study involving fifty-four Nigerian professionals and non-professionals, found that mistrust of the health system is directly linked to the misinterpretation of laboratory results leading to misdiagnosis, the dilapidation of medical equipment, and the perceived unprofessionalism of health workers, all of which participants associated with a broader pattern of institutional negligence. This mistrust carries practical behavioural consequences, as participants in the same study reported delaying or avoiding formal healthcare utilisation altogether, seeking informal alternatives instead, a pattern that itself compounds morbidity by postponing timely clinical intervention.

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The consequence, therefore, is cyclical: negligence produces harm, harm produces mistrust, and mistrust reduces engagement with the formal health system, further weakening the feedback mechanisms through which safety improvements might otherwise be identified and implemented.

Legal, Institutional, and Professional Obstacles to Redress

Victims of medical negligence in Nigeria confront a dense combination of legal, institutional, and professional obstacles that collectively render redress difficult to obtain.

At the legal level, Odunsi (2023) identifies the evidentiary burden as a primary barrier, noting that Nigerian courts require claimants to produce expert medical testimony establishing both the applicable standard of care and its breach, a requirement that is difficult to satisfy given the reluctance of practitioners to testify against professional colleagues. This reluctance is not incidental but structural, reflecting what Adegboyega (2024) describes as an implicit professional solidarity that discourages practitioners from providing evidence likely to result in the sanction of a peer, thereby depriving claimants of the very testimony their case requires. Litigation costs compound this evidentiary barrier; Odunsi (2023) notes that protracted court proceedings, often extending over several years, impose financial burdens that discourage all but the most determined or well-resourced claimants from pursuing a claim to conclusion.

Institutionally, the bodies charged with adjudicating professional misconduct present their own obstacles. Opara (2025), reviewing the roles of tribunals, regulatory bodies, and professional councils in proving medical negligence in Nigeria, finds that these institutions operate with overlapping and poorly coordinated mandates, such that a complaint may be redirected between disciplinary tribunals and regulatory councils without a clear, time-bound resolution pathway. This institutional fragmentation is not unique to Nigeria; a comparative study by Abor and Tetteh (2023) of teaching hospitals in Ghana found that only one of four hospitals examined demonstrated the simultaneous presence of financial, performance, and political accountability required for effective governance, indicating that weak institutional accountability structures constitute a regional rather than a purely Nigerian phenomenon within West African healthcare systems. Where such structures are weak, complainants have no reliable institutional channel through which to escalate an unresolved case, leaving many to abandon pursuit of a remedy altogether.

Professional obstacles further compound these legal and institutional barriers. The near-total absence of consequence documented by Iloh et al. (2017), in which none of the sixty-two practitioners who admitted to committing an error faced a lawsuit, reflects not merely a legal or institutional gap but a professional culture in which error disclosure to patients is actively discouraged; all sixty-two practitioners in that study demonstrated a negative attitude toward disclosing their errors to patients or families. This non-disclosure norm forecloses the possibility of redress at its earliest point, since patients who are not informed that an error occurred cannot reasonably be expected to initiate a claim.

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In all, the evidentiary demands of litigation, the fragmented and slow-moving character of regulatory oversight, and a professional culture resistant to disclosure combine to produce a system in which formal accountability for medical negligence in Nigeria remains, in practice, the exception rather than the norm.

Pathways Toward Strengthening Healthcare Accountability and Patient Safety Enforcement

The literature reviewed identifies several converging pathways through which healthcare accountability and patient safety enforcement in Nigeria might be strengthened, spanning institutional governance, regulatory reform, and professional culture.

At the institutional level, Abor and Tetteh (2023) argue that effective hospital governance requires the deliberate and simultaneous cultivation of financial accountability, ensuring proper allocation and use of resources, performance accountability, ensuring measurable service outcomes, and political accountability, ensuring responsiveness to public and regulatory oversight, since their comparative study found that hospitals achieving only partial accountability across these dimensions continued to exhibit persistent governance weaknesses. Applied to the Nigerian context, this suggests that patient safety enforcement cannot rely solely on disciplinary sanction after harm has occurred but must be embedded within routine institutional performance monitoring.

At the regulatory level, Croke and Ogbuoji (2024) contend that Nigerian health reform efforts have historically succeeded only where regulatory oversight of service providers is paired with transparent, digitally enabled monitoring linked to citizen feedback, allowing both government and the public to track compliance in a manner that reactive tribunal proceedings cannot achieve. Opara (2025) reaches a compatible conclusion from a legal perspective, recommending the harmonisation of the overlapping mandates currently held by disciplinary tribunals and professional regulatory councils, so that complaints of negligence follow a single, time-bound adjudicative pathway rather than being redirected between competing institutions.

Addressing the workforce dimension of negligence requires a distinct pathway. Ajoseh et al. (2024) caution against coercive retention measures, noting that a legislative attempt to restrain newly qualified doctors from emigrating was widely opposed by the Nigerian public and health professionals alike for failing to address the underlying push factors of poor remuneration and inadequate working conditions; their findings imply that sustainable workforce retention depends on improving the conditions that predispose practitioners to error in the first instance, rather than restricting mobility. Complementing this, Tamuno-opubo et al. (2024) recommend targeted investment in facility infrastructure, adequate staffing ratios, and the cultivation of open communication between healthcare workers and management, arguing that hierarchical institutional cultures which discourage the reporting of near misses perpetuate the very conditions that produce negligent outcomes.

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Finally, at the professional level, Peteet et al. (2023) advance a pathway grounded in the cultivation of accountability as a professional virtue rather than merely an externally imposed sanction, arguing that practitioners who are supported through non-punitive, learning-oriented reporting systems become more willing to disclose error, thereby generating the very evidence that both regulatory bodies and future patients require.

This professional-culture pathway aligns closely with the institutional recommendation advanced by Opara (2025) for accessible, non-adversarial complaint mechanisms, suggesting that the most durable route toward strengthened accountability in Nigeria lies not in any single legal or institutional reform but in the coordinated alignment of hospital governance, regulatory harmonisation, workforce retention, and a professional culture that treats disclosure of error as compatible with, rather than threatening to, continued practice.

Empirical Review

Ogueji et al. (2024) examined the health system factors driving medical negligence among healthcare providers in Nigeria. The study area comprised health facilities in Nigeria more broadly, with providers drawn from various practice settings between October and November 2023. The World Health Organization's health system building-blocks framework served as the theoretical underpinning, guiding the identification of workforce, infrastructural, and governance factors associated with negligent practice. The research adopted a qualitative survey design, drawing a purposively selected sample of fifty-one healthcare providers, with the six-item interview instrument pretested among eight additional providers prior to the main study. Data were collected through six open-ended questions administered to participants and analysed thematically. The major finding was that prolonged patient waiting times, inadequate history-taking, absent or poorly enforced procedural protocols, ill-equipped facilities, underdeveloped patient safety systems, and workforce shortages jointly account for negligent outcomes across the six building blocks examined. The study concluded that medical negligence in Nigeria is substantially health-system driven rather than attributable solely to individual practitioner failing.

This review grounded its analysis in a recognised systems framework and for allowing practitioners to describe negligence in their own terms, though its purposive sample of fifty-one providers limits the generalisability of its findings across Nigeria's diverse facility types. A gap covered by the current paper i.e the near-absence of the patient's own perspective, since the study captured only provider accounts of systemic negligence.

Iloh et al (2017) investigated medical errors among practitioners in Abia State, examining the prevalence, types, disclosure attitudes, and consequences of negligent practice. The study area was Abia State, southeastern Nigeria. The research was not explicitly anchored in a single named theory but was undergirded by the clinical risk management perspective on medical error, framed around the Hippocratic principle of avoiding harm. A cross-sectional descriptive design was

adopted, with a sample of one hundred and forty-five medical practitioners drawn from health facilities across the state; the sampling technique was not stated in fine detail beyond the selection of a representative cross-section of practising clinicians. Data were collected using a pretested, self-administered questionnaire eliciting information on error type, committal, disclosure attitude, and psychological consequence. The major finding was that 42.8% of practitioners had committed a medical error, with prescription errors, laboratory investigation errors, and diagnostic errors being most common, and that error committal was significantly associated with fewer than ten years of clinical experience; none of the affected practitioners had faced litigation, and over a third reported depressive symptoms. The study concluded that medical errors remain prevalent and under-sanctioned among Nigerian practitioners.

This study is valuable for its quantifiable, verifiable statistics, though its single-state focus restricts national applicability. A gap remains in that the study is that it did not examine facility-level or regulatory variables, which the present paper addressed more directly.

Abor and Tetteh (2023) examined accountability and transparency in hospital governance. The study area comprised four teaching hospitals in Ghana, a context closely comparable to Nigeria's healthcare governance environment. The research was grounded in Brinkerhoff's conceptual model of accountability, distinguishing financial, performance, and political or democratic accountability as its guiding constructs. A comparative case methodology was employed, with data drawn from structured questionnaires administered to hospital administrators across the four selected institutions, representing a purposive case-based sampling technique rather than a randomised population sample. The major finding was that only one of the four teaching hospitals demonstrated the simultaneous presence of financial, performance, and political accountability, with the same hospital also being the only one to practise both event and process transparency. The study concluded that most teaching hospitals examined exhibited significant accountability and transparency deficits of varying intensity.

This study is useful for its structured, multidimensional accountability framework and its explicit linkage between accountability and transparency, though its Ghanaian setting means its findings require cautious extrapolation to Nigeria. A gap remains in the study is the absence of equivalent multidimensional accountability assessment conducted within Nigerian hospitals themselves, a gap the current paper sought to narrow.

Kaware et al. (2022) assessed patient safety culture and its associated factors among nurses in Katsina State. The study area was twenty-one public secondary health facilities in Katsina State, northwestern Nigeria. The research was grounded in organisational safety culture theory, operationalised through the Agency for Healthcare Research and Quality's Hospital Survey on Patient Safety Culture instrument. A cross-sectional survey design was adopted, involving four hundred and sixty registered nurses selected across the twenty-one facilities, achieving a response rate of 93.5%. Data were collected using a self-administered structured questionnaire covering

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multiple safety culture composites. The major finding was that organisational learning, staffing, handoffs and transitions, and frequency of event reporting were the weakest composites, with multiple logistic regression confirming these as significant predictors of negative safety culture perception. The study concluded that a formal, mandatory error-reporting system, alongside targeted staff training, was necessary to strengthen patient safety enforcement.

This study is commendable for its large sample and statistically robust analysis, though it examined nursing staff exclusively and excluded physicians, pharmacists, and hospital administrators. But limited attention was paid to how such reporting mechanisms translate into disciplinary or legal accountability once errors are recorded, a linkage the current paper is positioned to explore.

Theoretical Framework: Organisational Accident Model

Organisational Accident Model, popularly known as the Swiss Cheese Model of accident causation was propounded by James Reason. Reason first articulated the model in 1990 in his analysis of the contribution of latent human failures to the breakdown of complex systems, and subsequently presented a simplified, widely adopted version in a paper published in the British Medical Journal in 2000, in which he distinguished the person approach from the system approach to human fallibility in healthcare and other high-risk industries.

The major assumptions of the theory rest on the proposition that adverse outcomes in complex organisations, including hospitals, rarely result from a single isolated error but occur when weaknesses in several layers of organisational defence align to allow a hazard to pass through undetected. Reason (2000) conceives of these defences as slices of cheese stacked in sequence, each containing holes that represent active failures, being the unsafe acts committed directly by frontline personnel such as doctors and nurses, and latent conditions, being the underlying systemic weaknesses embedded within management decisions, resource allocation, working conditions, and regulatory oversight.

The theory assumes that human beings are inherently fallible and that error cannot be eliminated by appealing to individual vigilance alone; rather, harm becomes possible only when the holes across multiple defensive layers momentarily line up, permitting a trajectory of accident opportunity to breach every barrier simultaneously.

A further assumption is that latent conditions, unlike active failures, may lie dormant within a system for a considerable period before combining with an active failure to produce a visible adverse event, meaning that the true origins of an incident are frequently traceable to decisions made well upstream of the point of care.

The theory carries clear strengths. It redirects analytical attention away from the individual practitioner and toward the systemic and organisational conditions that predispose personnel to error, thereby discouraging a reflexive culture of blame that can obscure the deeper causes of harm

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and inhibit honest reporting. It has been extensively applied across aviation, nuclear safety, and clinical medicine, and continues to inform contemporary patient safety scholarship, error-reporting frameworks, and root-cause analysis methodologies used in hospitals internationally. Its visual and conceptual simplicity also makes it readily communicable to healthcare professionals who may lack formal training in human factors science, allowing it to bridge academic and clinical audiences with unusual ease.

The theory nonetheless carries acknowledged weaknesses. Its metaphorical simplicity, while pedagogically useful, can encourage a mechanistic or overly linear reading of accident causation that understates the dynamic, interacting nature of real organisational failures. Critics have observed that the model, when applied rigidly, risks becoming a retrospective search for latent culprits rather than a genuine tool for prospective risk reduction, and that its diagrammatic form does not adequately distinguish between active and latent failures in practice. The theory has also been criticised for offering limited guidance on the specific legal, regulatory, and professional mechanisms through which accountability for aligned failures should ultimately be assigned once harm has occurred, a limitation of particular relevance to a study concerned not only with causation but with redress.

Applied to the present paper, the theory offers a coherent architecture for understanding medical negligence in Nigeria as the product of aligned systemic holes rather than isolated clinical misjudgement. The latent conditions identified throughout this paper, comprising workforce depletion arising from the emigration of trained personnel, infrastructural deficiencies such as ill-equipped facilities and absent protocols, and weak regulatory enforcement by disciplinary tribunals and professional councils, correspond directly to Reason's layered defences whose accumulated weaknesses create the conditions under which an individual practitioner's active failure, such as a retained surgical instrument or a misread diagnostic result, is able to reach the patient unimpeded.

The consequences documented in this paper, including morbidity, mortality, and the erosion of public confidence, represent the visible harm that materialises once a hazard trajectory has successfully penetrated every layer of defence. Correspondingly, the obstacles to legal and institutional redress examined in this paper can be understood as a further defensive layer, namely the accountability and justice system, whose own holes, evidentiary burdens, fragmented tribunal mandates, and professional reluctance to disclose error, permit negligent practice to persist without correction even after harm has occurred.

The pathways toward strengthened accountability and patient safety enforcement proposed in this paper are accordingly framed, within Reason's theory, as the deliberate narrowing of the holes within each defensive layer, achieved through improved staffing and retention, infrastructural investment, harmonised regulatory oversight, and a professional culture that treats error disclosure

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as compatible with continued practice, so that the alignment of failures required for patient harm becomes progressively less probable.

METHODOLOGY

This paper adopted a narrative, desk-based literature review methodology, whose with the to synthesise and critically interrogate existing scholarship on medical negligence, patient safety, and healthcare accountability in Nigeria rather than to generate new primary data. The review drew exclusively on secondary sources, comprising peer-reviewed journal articles, empirical studies, and doctrinal legal analyses retrieved from recognised academic databases and publisher platforms, and applied a defined set of inclusion criteria requiring that sources be scholarly in origin, traceable to identifiable and verifiable authors, published predominantly within the last five years to ensure contemporaneity, and directly relevant to at least one of the paper's four stated objectives concerning the causes, consequences, redress obstacles, and accountability pathways associated with medical negligence; sources lacking clear authorship, published in non-academic outlets such as newspapers, blogs, or organisational bulletins, or addressing contexts with no discernible relevance to Nigeria or comparable low- and middle-income healthcare settings, were correspondingly excluded.

This approach is justified on several grounds:

Firstly, given the breadth of the paper's objectives, spanning workforce, infrastructural, regulatory, legal, and institutional dimensions, a narrative review permitted the thematic integration of heterogeneous literatures, including clinical epidemiology, health systems research, and legal scholarship, that a narrowly quantitative or single-discipline systematic review would have struggled to accommodate.

Secondly, the methodology mirrors an established precedent within the subject area itself, as Tamuno-opubo et al. (2024) similarly employed a structured secondary-data review of empirical studies to characterise patient safety challenges in Nigeria, lending methodological legitimacy to the approach adopted here.

Thirdly, a review methodology was best suited to the paper's analytical purpose of interrogating the interpretive divergences among authors and situating their findings within a coherent theoretical framework, a task requiring critical synthesis rather than the generation of fresh empirical measurement.

DISCUSSION

On the question of causation, a discernible tension exists between authors who locate the principal driver of negligence in workforce depletion and those who locate it in facility-level and regulatory deficiency. Udom et al. (2024), Ajoseh et al. (2024), and Umar et al. (2025) each treat the emigration of trained personnel as the foremost pressure point, arguing that the resulting shortage

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compels remaining practitioners to operate beyond safe caseloads. This emphasis is intuitively persuasive and is lent empirical weight by Iloh et al.'s (2017) finding that error committal was significantly associated with fewer than ten years of clinical experience, a pattern consistent with junior, less experienced staff being disproportionately deployed to cover shortfalls left by emigrating seniors.

Yet Ogueji et al. (2024b) complicate this workforce-centred account by demonstrating, through direct interviews with providers, that negligence persists even where staffing pressures are held constant, driven instead by the absence of basic equipment, unstandardised procedures, and poor history-taking practices that would remain even if emigration were halted tomorrow. The implication worth interrogating is that workforce migration, while undeniably significant, may function less as a root cause than as an accelerant of pre-existing structural weaknesses; a fully staffed hospital lacking functioning diagnostic equipment or enforced clinical protocols would, on Ogueji et al.'s evidence, remain vulnerable to negligent outcomes. Odunsi (2023) and Adegboyega (2024) add a third causal layer largely absent from the workforce-focused literature, namely the near-total absence of routine, independently verified regulatory inspection, a gap that allows both staffing and infrastructural weaknesses to go uncorrected for extended periods.

The consequences documented across the reviewed literature likewise resist reduction to a single register. Iloh et al. (2017) offer a clinically precise, quantifiable account, showing that prescription errors occurred in 95.2% of negligence cases, laboratory investigation errors in 83.9%, and diagnostic errors in 69.4%, figures that ground the discussion of morbidity in measurable, replicable data rather than impression. Ogueji et al. (2024a), by contrast, direct attention toward a consequence that resists straightforward quantification, namely the erosion of public trust, evidenced qualitatively through participants' accounts of misdiagnosis, dilapidated equipment, and avoidance of formal care.

Collectively, these two studies suggest that the consequences of negligence in Nigeria operate on two interacting registers: an immediate clinical register measurable in error rates and patient morbidity, and a slower-moving social register measurable in declining health-seeking behaviour. Tamuno-opubo et al. (2024) provide the analytical bridge between these registers, arguing that a weak patient safety culture prevents the clinical register from ever being corrected, since facilities lacking structured incident review cannot convert individual clinical errors into system-wide learning, allowing the same failures to recur and further entrenching the mistrust that Ogueji et al. (2024a) documented.

The case of a retained surgical instrument later requiring emergency removal, of the kind described in Nigerian hospital incident reporting more broadly (Abdullahi, 2026), illustrates this interaction concretely: a single clinical error becomes, once publicised, a data point in the erosion of confidence that Ogueji et al. (2024a) describe, demonstrating that the clinical and social consequences of negligence are not sequential but mutually reinforcing.

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The discussion of legal, institutional, and professional obstacles to redress reveals perhaps the sharpest disagreement in emphasis among the reviewed authors. Odunsi (2023) and Adegboyega (2024) frame the obstacle predominantly in evidentiary and procedural terms, centring on the difficulty of securing expert testimony and the protracted cost of litigation. Opara (2025) shifts the emphasis toward institutional fragmentation, arguing that overlapping tribunal and regulatory council mandates leave complainants without a clear adjudicative pathway. Both accounts, however, understate what Iloh et al.'s (2017) empirical finding starkly reveals: that none of the sixty-two practitioners who admitted to committing an error in their sample faced any lawsuit, and that all sixty-two exhibited a negative attitude toward disclosing the error to patients.

This finding suggests that the obstacle to redress begins before any legal or institutional process is engaged at all, in a professional culture of non-disclosure that forecloses the possibility of a claim being filed in the first instance. Abor and Tetteh's (2023) comparative evidence from Ghana, where only one of four teaching hospitals examined demonstrated coherent financial, performance, and political accountability, corroborates the institutional dimension of this obstacle while suggesting that weak accountability structures are not a uniquely Nigerian pathology but a regional feature of West African hospital governance, a point the doctrinal legal literature focused narrowly on Nigeria tends to overlook.

Regarding pathways toward reform, a productive tension emerges between authors who favour institutional and regulatory solutions and those who favour cultivating professional disposition. Croke and Ogbuoji (2024) and Opara (2025) advocate structural remedies, namely digitally enabled regulatory monitoring and the harmonisation of tribunal mandates, while Peteet et al. (2023) argue that accountability must additionally be cultivated as a professional virtue, since no institutional mechanism can compel disclosure from a practitioner determined to conceal error. Ajoseh et al.'s (2024) finding that a coercive legislative attempt to restrain doctors from emigrating was rejected by the very public it was meant to protect lends weight to the view that structural reform imposed without addressing underlying working conditions is unlikely to succeed, reinforcing rather than resolving the tension between institutional and dispositional approaches. The most defensible position emerging from this discussion is that neither approach is sufficient in isolation: Kaware et al.'s (2022) finding that organisational learning and event-reporting frequency were the weakest composites of safety culture among Katsina nurses demonstrates that structural reporting mechanisms and a receptive professional culture are interdependent, since a reporting system without a culture willing to use it, or a virtuous disposition without a channel through which to act on it, both fail to produce accountability.

The theoretical framework adopted in this paper, Reason's (2000) Organisational Accident Model, lends coherent structure to these otherwise divergent findings. By conceiving of medical negligence as the product of aligned weaknesses across successive layers of organisational defence rather than the isolated failing of any single actor, the theory accommodates the workforce,

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infrastructural, and regulatory causes identified by Udom et al. (2024), Ogueji et al. (2024b), and Odunsi (2023) as concurrent latent conditions occupying distinct defensive layers, none of which alone is sufficient to produce harm but which, once aligned, permit an active failure, such as a misread laboratory result or a retained surgical instrument, to reach the patient unimpeded.

The theory equally accommodates the consequences documented by Iloh et al. (2017) and Ogueji et al. (2024a) as the visible outcome of a hazard trajectory that has successfully penetrated every barrier, and it reframes the legal and institutional obstacles examined through Odunsi (2023), Adegboyega (2024), and Abor and Tetteh (2023) as a further defensive layer whose own holes, evidentiary burden, tribunal fragmentation, and non-disclosure culture, permit negligence to persist uncorrected even after harm has occurred.

Most usefully, the theory resolves the apparent disagreement between structural and dispositional reform advocates identified in the discussion of pathways, since Reason's model treats both organisational systems and individual professional behaviour as components of the same layered defence, meaning that Croke and Ogbuoji's (2024) regulatory monitoring and Peteet et al.'s (2023) professional virtue are not competing remedies but complementary narrowings of holes within adjacent layers.

In this sense, the theoretical framework does not merely describe the findings of this paper but actively integrates them, providing a single explanatory architecture within which the causes, consequences, obstacles, and pathways examined throughout this study can be understood as interacting elements of one systemic failure rather than as separate and unrelated problems.

CONCLUSION

This paper examined medical negligence and patient safety in Nigeria by interrogating the causes embedded within the country's workforce, infrastructural, and regulatory arrangements, the consequences borne by patients and the wider health system, the obstacles that frustrate victims seeking redress, and the pathways through which accountability might be strengthened. The evidence assembled across these four objectives demonstrates that medical negligence in Nigeria cannot be reduced to the isolated failing of individual practitioners, however frequently such framing dominates public discourse following a particular tragedy.

Rather, negligence emerges from the sustained alignment of depleted staffing occasioned by professional emigration, facilities operating without the basic equipment and protocols that safe practice requires, and a regulatory architecture whose oversight remains largely reactive rather than preventive. The consequences of this alignment are neither trivial nor confined to the clinical encounter in which they occur; they extend into measurable patient morbidity and mortality, into the psychological burden borne by practitioners themselves, and into a slower, cumulative erosion of public confidence that discourages timely engagement with formal healthcare and thereby compounds the very harm the system was meant to prevent.

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Compounding this cycle is a redress architecture in which evidentiary burdens, fragmented tribunal mandates, and a professional culture resistant to disclosure combine to ensure that negligence, once it occurs, is rarely followed by consequence for the practitioner or remedy for the patient, a pattern starkly illustrated by empirical evidence that practitioners who admit to committing error are seldom, if ever, subject to litigation.

RECOMMENDATIONS

Arising from these findings, three actionable recommendations are proposed.

1. Firstly, in direct response to the causes identified, health sector authorities and hospital administrators should institute mandatory, independently verifiable clinical protocols and minimum equipment standards for both public and private facilities, enforced through unannounced inspection regimes rather than the largely self-reported compliance mechanisms currently in use, thereby narrowing the infrastructural and workforce-related holes that permit active clinical failures to reach patients.
2. Secondly, addressing the consequences and the erosion of public confidence documented in this study, hospital management boards should establish non-punitive, structured incident-reporting systems modelled on the composites shown to be weakest in existing Nigerian safety culture assessments, namely organisational learning and event reporting, so that clinical errors generate institutional learning rather than concealment, thereby interrupting the cycle through which unaddressed harm deepens patient mistrust.
3. Thirdly, in response to the legal and institutional obstacles obstructing redress, the National Assembly and relevant regulatory councils should harmonise the overlapping mandates currently divided between disciplinary tribunals and professional regulatory bodies into a single, time-bound adjudicative pathway, complemented by state-subsidised access to independent medical expert testimony, so that the evidentiary and financial barriers presently deterring aggrieved patients from pursuing legitimate claims are substantially reduced.

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