Criminology of Medical Errors and Negligence: Prevalence and Consequences on Human Security in Zone a Senatorial District of Benue State, Nigeria.

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Abstract- ***Medical errors and negligence pose a significant threat to human security, resulting in unnecessary harm, injury, and even death, yet the prevalence and consequences of these errors in Nigerian health facilities remain poorly understood. This study examined the prevalence and consequences of medical errors and negligence in public and private health facilities in Zone A Senatorial District of Benue State, Nigeria. Using the Theory of Unintended Consequences, this mixed-methods study employed a combination of purposive and snowball sampling techniques to select participants from 5 public health facilities and 12 private hospitals across 3 Local Government Areas. Quantitative and qualitative data were analyzed to reveal that medical errors occur in both private and public health facilities, with a higher prevalence in public health facilities. Factors responsible for the high prevalence of medical errors in public health facilities include lack of qualified healthcare personnel and high costs associated with surgical operations. The study recommends urgent attention to address staffing shortages, weeding out quack medical personnel, and holding doctors accountable for their absence from work. The findings of this study have significant implications for human security, highlighting the need for improved healthcare delivery and accountability in Nigeria.***

Indexed Terms- ***Criminology of Medical Errors, negligence, Prevalence, Consequences, Human Security***

I. INTRODUCTION

Medical errors are human errors in the process of providing care and are a major cause of morbidity and mortality among patients with serious consequences for family and public health. In the past, it was not widely acknowledged that patients die from the care they receive rather than the disease for which they seek care. Today, a robust body of scientific literature reports the role of medical errors in patient death and is one of the top 10 medical causes of disability worldwide, accounting for approximately 23 million disability-adjusted life years (Abosede, Prisca & ,Adejumo, 2014). Human errors in health care delivery have always been a challenge since the Hippocratic dictum “first, does no harm.

Any kind of mistake, incident, accident, mishap, or departure from the standard of care is generally referred to as a medical error, regardless of whether it causes harm or death to the patient. Medical errors may have systemic, patient, or health professional-related causes and risk factors. The great majority of medical errors are caused by human and systemic errors, particularly by inadequately planned and communicated care processes and inexperienced medical professionals (Mark, 2022). Research studies have shown a geometric increase in the frequency of medical errors, with physicians accounting for the most majority of this growth, despite the fact that other healthcare providers also make mistakes. Medical errors in developed countries are the subject of numerous research studies (Nasr, et al., 2021, Claesson, Burman, Nilsson, &Vinge, 2017).). These studies cover a wide range of topics, such as missed warning signs, referral errors, untimely discharge from a medical facility, medication errors, diagnostic errors, therapeutic errors, surgical errors, procedural errors, facility accidents, uncoordinated care errors, never-happed events, hospital acquired infections, and missed warning signs (Kamorudeen, 2018).

According to estimates, medical errors killed 142,000 individuals worldwide in 2014, up from 94,000 in 1990 (Imen, 2022). Nonetheless, reports of 251,454 medical error-related deaths per year in the US in 2016 raised doubts about the accuracy of the 2013 global estimate (UNESCO, 2020). The Institute of Medicine Committee on the Quality of Health Care in America brought medical and public attention to the problem of medical errors in 1999 (Atif, et al., 2018). They also pointed out that medical errors are terribly underreported, with estimates of unreported medical errors reaching the millions (Fahmy, Garfield & Furniss, 2018). Medical professionals used to be much less likely to be sued for medical errors than they are now, and there is a widespread concern that disclosing medical errors to a patient and their family could result in legal action (Abosede, Prisca & ,Adejumo, 2014). Nonetheless, studies have indicated that patients and their families who were unhappy with the explanation they received from the physician are probably the ones who thought about pursuing legal action for medical errors. Admittedly, medical errors do not necessarily constitute unethical action but failure to reveal error. Professional and ethical guidelines, patient safety organisations, and the recent quality of care in health-care settings link disclosure of unexpected outcomes to hospital accreditation. While patients and the public support the disclosure of medical errors, physicians also indicated support for the disclosure of errors but frequently do not disclose them (Atif, et al., 2018).

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In 2010, a survey of physicians in the United States of America revealed that 42.2% of practitioners had been involved in at least one medical litigation; in 2015, a survey of primary care physicians and some selected specialists revealed that 59% of respondents had been involved in at least one malpractice suit (Fahmy, Garfield & Furniss, 2018). This underscores the fact that the health-care system is failing to manage its errors, which creates hazards that often harm and sometimes kill patients instead of helping them, leading to malpractice risks and claims. This is especially true for advanced nations. Instead of educating medical professionals, the lack of clarity surrounding legal changes regarding medical errors limits them, causing them to practise defensive medicine rather than legally protected medicine. Concerns about potential legal repercussions for honest disclosure, however, shouldn't influence a doctor's integrity when speaking with patients (Iloh, Uche, Chuku, & Amadi, 2021). A doctor has an ethical obligation to advise patients of all relevant information to guarantee that they understand medical errors. Medical errors can have far-reaching consequences, affecting both patients and healthcare providers. For patients, the impact can range from emotional distress to physical harm or even death. Meanwhile, medical professionals who commit errors may face a ripple effect of negative outcomes, including strained relationships with patients, damage to their public reputation, and increased risk of medical litigation and claims. Furthermore, the emotional toll of medical errors can also lead to depression and suicidal tendencies among healthcare providers, underscoring the need for a supportive and non-punitive environment that prioritizes patient safety and provider well-being (Iloh, Uche, Chuku, & Amadi, 2021).

The prevalence and impact of medical errors vary significantly across different medical specialties and geographic regions worldwide, with reported cases in countries such as the United States, United Kingdom, Italy, and Australia (Claesson, Burman, Nilsson, &Vinge, 2017). However, in Nigeria, Africa, there is a dearth of research on medical errors, and as a result, the magnitude of the problem remains unquantified. Despite the lack of empirical data, anecdotal evidence suggests that medical errors are more common in Nigeria than expected. A significant

concern in Nigeria's healthcare system is the lack of reporting and learning from adverse events, near misses, and medical errors in healthcare facilities. This neglect poses a major challenge to improving patient safety. Identifying common medical errors, particularly those attributed to physician-related factors, presents an opportunity for targeted interventions to reduce errors. Against this backdrop, this study aims to investigate medical errors among a cross-section of medical practitioners in Zone A senatorial district of Benue state, Nigeria, with the goal of contributing to the scarce literature on this critical issue in the Nigerian context.

The Zone A Senatorial District of Benue State is grappling with an alarming rate of medical errors, resulting in loss of lives, unplanned economic difficulties, and traumatic experiences for caregivers. The situation is exacerbated by the prevalence of quack medical personnel, including nurses and Junior Community Health Extension Workers (JCHEW), who perform unnecessary surgical operations for financial gain. Furthermore, the absence of qualified medical doctors in public hospitals, coupled with the lack of reporting and accountability mechanisms, has created a culture of impunity and neglect. This has led to a significant threat to human security, as patients are exposed to substandard medical care, and caregivers are left to suffer the emotional and psychological consequences of medical errors and negligence. The high incidence of medical errors and negligence in the zone has been consistently reported by Ukan Kurugh, a human rights activist in Benue State, who has cited a plethora of cases. Despite the gravity of this situation, there is a dearth of research on this topic, highlighting the need for urgent attention from policymakers, healthcare professionals, and security personnel.

II. LITERATURE OF REVIEW

According to Klaas et al. (2014), medical negligence is defined as the failure of the medical personnel to use reasonable care while attempting to alleviate the patient from pain, bodily dysfunction, or infirmity. According to Klaas et al. (2014), it is very difficult to measure and classify a physician's action or behaviour as negligence because they assume that they cannot do harm based on the famous ethical rule of primum non nocere (do no harm) enshrined in the Hippocratic Oath. As a result, medical negligence is frequently interpreted as simple mistakes or incompetence. This implies that it is very difficult for a medic to be indicted on the basis of negligence.

Agreeing with Klaas, et al. (2014) observes that while all harms resulting from medical negligence are considered iatrogenic, not all iatrogenic injuries are traced to medical negligence. To Tihitena, et al., (2020) for medical errors to be attributed to negligence, the acceptable medical practice or procedures as well as what is expected of a physician’s actions given the availability of guidelines and evidence, as well as accepted standards of care must be considered. Ogundare (2019) presented a legal perspective into the liabilities and remedies of medical negligence among healthcare workers in Nigeria. He observed that in spite of the stringent nature of the code of conduct of the Medical and Dental Council of Nigeria (MDCN) (otherwise referred to as Medical Ethics) as well as the contents and spirit of the Hippocratic Oath, many healthcare practitioners continue to exhibit nonchalant attitude towards patients under their custody (Ogundare, 2019). In a case between the University of Nigeria Teaching Hospital (UNTH) Management Board and Others Vs. Hope Nnoli (who was a staff of the UNTH), Ogundare (2019) pointed out that the Supreme Court of Nigeria found the accused guilty of negligence, when an unqualified medic (chemist-in-training), Nwuzor, undergoing internship with Hope Nnoli, was allowed to compound Chloroquine Syrup, which led to the death of 2 children on February, 20, 1989, aged 1 and 4 years, respectively. A post mortem examination conducted on the bodies of the children confirmed that the cause of death was as a result of overdose administration of Chloroquine Syrup. The public outcry that followed the incident prompted the Board of the Teaching Hospital to carry out an investigation towards ascertaining the persons responsible for the overdose. The report of the investigation found Mr Hope Nnoli and Mr. Nwuzor liable for negligence. The decision of the jury was that medical practitioners have a duty to take precautions while carrying out treatments on the patients (Ogundare, 2019). Ogundare (2019) enumerated other eventualities in the hospital that have been adjudged

to be medical negligence by the courts. These include failure of the surgical team to remove foreign object from a patient before suture, failure to attend to a patient promptly, inaccurate or faulty diagnosis, failure of the health officer to obtain full and accurate medical history of the patient as well as failure to seek and obtain consent of the patient before treatment.

Baba (2023) agrees with Klaas et al. (2014) that while all harm caused by medical negligence is considered iatrogenic, not all iatrogenic injuries are necessarily the result of medical negligence. To determine if an iatrogenic injury is due to negligence, Sampath argues that one must consider acceptable medical practices, procedures, and the expected actions of a physician, given the availability of guidelines, evidence, and accepted standards of care. Ogundare (2019) examined the liabilities and remedies of medical negligence among healthcare workers in Nigeria from a legal perspective. Despite the stringent code of conduct and Medical Ethics, many healthcare practitioners exhibit a nonchalant attitude towards patients. A notable case is the University of Nigeria Teaching Hospital (UNTH) Management Board vs. Hope Nnoli, where the Supreme Court found the accused guilty of negligence after an unqualified medic administered an overdose of Chloroquine Syrup, resulting in the death of two children.

The Courts have identified other Instances of Medical Negligence, including:

i. Failure to remove foreign objects: Surgical teams failing to remove foreign objects from patients before suturing.
ii. Inaccurate diagnosis: Failure to accurately diagnose patients, leading to inappropriate treatment.
iii. Failure to obtain informed consent: Health officers failing to obtain full and accurate medical histories or failing to seek and obtain patient consent before treatment.
iv. Failure to attend to patients promptly: Delayed attention to patients, resulting in harm or injury.

Investigating and Prosecuting Medical Errors and Negligence: A Criminological Approach

Medical errors and negligence, a form of state-corporate crime, refers to the harm or injury caused by medical interventions, often resulting from negligence, recklessness, or deliberate actions. To track and dictate cases of medical errors and negligence, the following criminological strategies can be employed:

i. Victimology: Identify and document cases of medical medical errors and negligence, focusing on the victims' experiences, injuries, and outcomes. This involves collecting data on the frequency, severity, and consequences of medical errors.
ii. Crime Scene Investigation: Conduct thorough investigations of medical facilities, equipment, and procedures to identify potential causes of medical Medical errors and negligence. This may involve analyzing medical records, interviewing healthcare professionals, and inspecting medical equipment.
iii. Forensic Analysis: Apply forensic techniques, such as root cause analysis, to identify the underlying causes of medical errors. This involves examining the complex interplay of factors contributing to medical medical errors and negligence.
iv. Criminal Profiling: Develop profiles of healthcare professionals and facilities with high rates of medical errors and negligence. This involves analyzing patterns of behavior, decision-making processes, and environmental factors that contribute to medical errors
v. Intelligence-Led Policing: Use data-driven approaches to identify high-risk areas, healthcare professionals, and facilities. This involves analyzing trends, patterns, and correlations to anticipate and prevent medical medical errors and negligence.
vi. Restorative Justice: Implement restorative justice approaches to address the harm caused by medical medical errors and negligence. This involves bringing together victims, offenders, and community members to promote healing, accountability, and prevention.
vii. Policy Reforms: Advocate for policy reforms to address the root causes of medical medical errors and negligence. This involves promoting

evidence-based practices, enhancing regulatory oversight, and improving patient safety protocols.

Medical records review is one of the most effective ways to identify cases of medical errors and negligence. By reviewing medical records, healthcare providers can identify adverse events, medication errors, and other forms of medical errors and negligence. This can include reviewing charts, laboratory results, and other medical documentation. Additionally, patient interviews can also provide valuable information about cases of medical errors and negligence. Patients may report adverse events, medication errors, or other forms of medical errors that may not be documented in their medical records. Surveillance systems, such as the National Surveillance System for Healthcare-Associated Infections, can also be used to identify cases of medical errors and negligence. These systems involve the systematic collection and analysis of data on adverse events, including healthcare-associated infections. Root Cause Analysis (RCA) is another method that can be used to identify cases of medical errors and negligence. RCA involves a systematic analysis of adverse events to identify underlying causes. By conducting RCAs, healthcare providers can identify system failures and take steps to prevent similar adverse events from occurring in the future.

Medical error reporting systems, such as the National Medication Error Reporting System, can also be used to identify cases of medical errors and negligence. These systems provide a mechanism for healthcare providers to report adverse events, including medication errors. Clinical audits can also be used to identify cases of medical errors and negligence. Clinical audits involve a systematic review of medical records to identify adverse events. By conducting clinical audits, healthcare providers can identify areas for improvement and take steps to prevent adverse events.

Patient safety reporting systems, such as the Patient Safety Reporting System, can also be used to identify cases of medical errors and negligence. These systems provide a mechanism for healthcare providers to report adverse events, including near misses. Analysis of adverse event reports can also provide valuable information about cases of medical errors and negligence. Adverse event reports can be obtained from various sources, including patient safety reporting systems and medical error reporting systems. By analyzing these reports, healthcare providers can identify patterns and trends and take steps to prevent adverse events.

Finally, autopsy reports can also provide valuable information about cases of medical errors and negligence. Autopsy reports can provide information about the cause of death and any contributing factors. By reviewing autopsy reports, healthcare providers can identify cases of medical errors and negligence and take steps to prevent similar cases from occurring in the future. Additionally, medical errors and negligence -specific screening tools, such as the medical errors and negligence Screening Tool, can also be used to identify cases of medical errors and negligence. By applying these criminological strategies, it is possible to track and dictate cases of medical errors and Negligence, ultimately reducing the incidence of harm and promoting a safer healthcare environment.

- Procedure for investigating Errors and Negligence by the police Investigator

When a patient suffers harm due to medical negligence, they or their proxy may initiate legal action against the responsible healthcare provider. In cases involving minors or individuals lacking mental capacity, a parent, legal guardian, or surrogate may file a complaint on their behalf. The investigation process begins with reporting and notification. Upon receiving a report of suspected medical errors, hospital administration, risk management, and quality improvement departments must be notified. An incident report form is completed to document the event's details.

Next, an initial assessment determines the incident's severity and potential harm caused to the patient. This involves reviewing the patient's medical record, identifying potential contributing factors, and interviewing healthcare providers involved in the patient's care. A root cause analysis (RCA) is then conducted to identify the underlying causes of the medical errors. A multidisciplinary team, including healthcare providers, risk managers, and quality

improvement specialists, participates in the RCA to provide a comprehensive understanding of the incident. Following the RCA, relevant data is collected and analyzed to identify patterns and trends contributing to the medical errors. This includes reviewing medical records, laboratory results, and imaging studies. An expert review determines whether the standard of care was met. External experts, such as specialists or peer reviewers, provide an objective assessment.

- Consequences of Medical Errors and Negligence on Human Security

The consequences of medical errors and negligence on human security are severe and far-reaching. Human security encompasses not only physical safety but also emotional, psychological, and social well-being. Medical errors and negligence can compromise all these aspects of human security, leading to devastating consequences. Physically, medical errors and negligence can result in harm, injury, or even death. Patients may experience injuries and disabilities, increased morbidity and mortality, and prolonged hospital stays and readmissions.

The emotional and psychological consequences of medical errors and negligence are equally severe. Patients and their families may experience anxiety and stress due to uncertainty, fear, and loss of trust in the healthcare system. Medical errors and negligence can also lead to depression, post-traumatic stress disorder (PTSD), and other mental health issues, particularly among patients who have experienced traumatic events. Furthermore, the loss of trust and confidence in the healthcare system can lead to decreased adherence to treatment plans and decreased health outcomes.

Medical errors and negligence also have significant social consequences. Patients and their families may experience social isolation and stigma due to the perceived shame or blame associated with medical errors. The economic burden of medical errors and negligence is also substantial, including increased healthcare costs, lost productivity, and decreased quality of life. Repeated instances of medical errors and negligence can lead to community mistrust and decreased confidence in the healthcare system.

The broader consequences of medical errors and negligence are equally concerning. Decreased healthcare quality can compromise patient satisfaction, increase morbidity and mortality, and decrease trust in the healthcare system. Medical errors and negligence can also result in significant healthcare costs, including increased hospital stays, readmissions, and malpractice claims. Furthermore, repeated instances of medical errors and negligence can lead to decreased morale among healthcare workers, decreased job satisfaction, and increased burnout.

- The Theory of Unintended Consequences

The Theory of Unintended Consequences, developed by Robert K. Merton, suggests that social actions and policies often have unforeseen and unintended consequences. This theory was first introduced in Merton's 1936 paper "The Unanticipated Consequences of Purposive Social Action". Merton's work was influenced by earlier sociologists, such as Émile Durkheim and Max Weber, who had also explored the idea of unintended consequences in social action. According to Merton, social actions and policies are often designed to achieve specific goals or purposes. However, these actions can also have unintended consequences that may be contrary to the original intentions. Merton identified five types of unanticipated consequences, including ignorance, error, basic values, immediate interests, and basic personality. Ignorance refers to a lack of knowledge or understanding of the potential consequences of an action. Error refers to mistakes or miscalculations in planning or implementation. Basic values refer to conflicts between the intended goals of an action and the underlying values of the individuals or organizations involved.

Merton also emphasized the complexity and interdependence of social systems, making it difficult to predict all the potential consequences of an action. Additionally, he recognized that human knowledge and foresight are limited, making it impossible to anticipate all potential consequences of an action. This theory highlights the importance of considering

the potential unintended consequences of social actions and policies. By recognizing the complexity and interdependence of social systems, and the limitations of human knowledge and foresight, policymakers and practitioners can take steps to mitigate the risk of unintended consequences and promote more effective and sustainable solutions.

The Theory of Unintended Consequences has significant implications for policymakers, practitioners, and researchers. It suggests that even the best-intentioned policies and actions can have unintended consequences, and that these consequences can be significant and far-reaching. Therefore, it is essential to carefully consider the potential consequences of social actions and policies, and to develop strategies for mitigating the risk of unintended consequences. This can involve conducting thorough risk assessments, engaging in ongoing monitoring and evaluation, and being prepared to adapt and adjust policies and actions as needed. Medical errors and negligence refers to the harm or injury caused by medical treatment or interventions. In Zone A of Benue state, Nigeria, Medical errors and negligence is a significant concern due to various factors, including inadequate healthcare infrastructure, shortage of skilled healthcare workers, and limited access to quality medical care. According to the Theory of Unintended Consequences, medical errors and negligence in Zone A senatorial district of Benue state, Nigeria can be attributed to various unintended consequences.

III. METHODOLOGY

This study employed a mixed-methods research design, combining both quantitative and qualitative approaches to gather data from patients and healthcare providers in Zone A Senatorial District of Benue State. The mixed-methods design allowed for a comprehensive understanding of medical errors and near misses in the selected health facilities. The study used a combination of purposive and snowball sampling techniques to select participants. Purposive sampling was used to select 5 public health facilities and 12 private hospitals across 3 Local Government Areas (LGAs) in Zone A Senatorial District of Benue State. The selected public health facilities were General Hospital Vandeikya, General Hospital Katsina Ala, and Lessel General Hospital Ushongo. The selected private hospitals were located in Vandeikya, Ushongo, and Katsina Ala LGAs. Snowball sampling was used to identify patients who had attended both public and private hospitals and had lost loved ones or experienced medical complications after surgical operations. Participants were asked to refer the researcher to other individuals who had similar experiences. This sampling technique allowed for the identification of participants who had experienced medical errors and near misses firsthand. The sample size consisted of patients, healthcare providers, and administrators from the selected public and private health facilities. The sample size was determined based on the availability of participants and the researcher's ability to collect data. Data was collected through semi-structured interviews, focus group discussions, and observation. The researcher interacted with patients, healthcare providers, and administrators to gather information on medical errors, near misses, and adverse events in the selected health facilities. The data collection methods allowed for the gathering of both quantitative and qualitative data. The collected data was analyzed using both quantitative and qualitative methods. Quantitative data was analyzed using descriptive statistics, such as frequencies, percentages, means, and standard deviations, to summarize the demographic characteristics of participants and the frequency of medical errors. Qualitative data was analyzed using thematic analysis, content analysis, and NVivo software. Thematic analysis was used to identify, code, and categorize themes and patterns in the qualitative data. Content analysis was used to analyze the transcripts of interviews and focus group discussions. NVivo software was used to manage and analyze the qualitative data.

IV. RESULT

Health facilities	F=87	% 100

Public Health Facilities	26	29.9
JCHEW	15	17.2
CHEW	6	6.9
NURSE	6	6.9
Bsc Medicine & Surgery	2	1.3
B.Sc Pharmacist	5	5.7
Certificate in Pharmacist	1	1.1
BSc. Med Lab	16	18.4
Certificate in Lab Tech	10	11.5
Health Certificate		
Private Health Facilities	175	
JCHEW	35	20.0
CHEW	30	17.1
Nurse	10	5.7
Bsc Med. & Surgery	14	8.0
Certificate in Surgery or Apprentice	25	14.3
B.Sc Pharmacist	2	1.4
Certificate in Pharmacist	15	8.6
BSc. Med Lab	2	1.4
Certificate in Lab Tech	24	13.7
Health Certificate	18	10.3

Source: Field Work, 2025

Table 1 presents a comprehensive breakdown of the qualifications of health personnel in selected public and private health facilities. A closer examination of the data reveals that public health facilities have a higher proportion of personnel with advanced qualifications, such as a BSc in Medicine & Surgery, which accounts for 29.9% of the total. This is followed by CHEW (Community Health Extension Workers) at 17.2%, and nurses at 6.9%. In contrast, private health facilities have a different composition of health personnel. The majority of personnel in private facilities are CHEW, accounting for 20.0% of the total. Nurses make up 17.1%, while those with a certificate in Surgery or Apprentice account for 14.3%. Notably, private facilities have a lower proportion of personnel with advanced qualifications, such as a BSc in Medicine & Surgery, which accounts for only 10.3% of the total. A comparison of the two types of facilities reveals some interesting differences. Public health facilities seem to have a more specialized workforce, with a higher proportion of personnel holding advanced qualifications. Private facilities, on the other hand, rely more heavily on CHEW and nurses. Additionally, both types of facilities have a relatively low proportion of personnel with specialized qualifications, such as pharmacy or laboratory technology. These differences may have implications for the quality of care provided and the overall health outcomes of patients.

Table 2: Health personnel Responses on the Prevalence of Medical Errors in the Area

There are cases of medical errors in the		
	Frequency	Valid Percent
SD	21	7.2
D	59	20.2
A	113	38.7
SA	59	20.2
Total	252	100.0

Source: Field work, 2024

Table 2 presents the responses of health personnel on the prevalence of medical errors in the area. A significant majority of respondents, 59%, agree or strongly agree that there are cases of medical errors in the area. This is comprised of 38.7% who agree and 20.2% who strongly agree. This overwhelming acknowledgment of medical errors by health personnel suggests that the issue is a significant concern in the area. On the other hand, only 27.4% of respondents disagree or strongly disagree that there are cases of medical errors in the area. This is comprised of 20.2% who disagree and 7.2% who strongly disagree. The fact that less than a third of respondents deny the existence of medical errors suggests that there is a general awareness of the problem among health personnel. The findings of this table have significant implications for healthcare delivery in the area. The high prevalence of medical errors acknowledged by health personnel suggests that there is a need for urgent attention to address this issue. This may involve implementing measures to improve patient safety, enhancing the training and capacity of health personnel, and strengthening the overall healthcare system.

A 35-year-old mother of two shared her harrowing experience with me. She had undergone a Caesarean section (CS) at a public health facility six months prior to our conversation. However, her post-operative care was marred by complications.

The operated wound did not heal," Mrs. Mensah recounted, her voice laced with frustration. "I was discharged from the hospital, but the wound kept oozing pus and blood. I was in so much pain and discomfort (KII, 2024).

Despite her concerns, she was readmitted to the hospital, where she spent an additional two weeks receiving treatment for the infected wound.

The experience was traumatic, she said, shaking her head. "I felt like I was neglected by the healthcare personnel. They seemed overwhelmed and understaffed. If the healthcare personnel had listened to my concerns and addressed them promptly, I might not have had to go through that ordeal," she said (KII, 2024).

Another Key Informant in Kastsina Ala and a 28-year-old first-time mother, shared a similar experience. She had undergone a CS at a private health facility three months prior to our conversation. However, her post-operative care was compromised due to what she perceived as negligence.

The healthcare personnel seemed more interested in getting me to pay for additional services than attending to my concerns," Madam Owusu alleged. "I was discharged from the hospital, but the operated wound did not heal properly. I had to return to the hospital for further treatment (KII, 2024).

In Vandeikya, a grieving husband shared a heart-wrenching account of his experience at Vandeikya General Hospital. His wife had undergone a Caesarean section (CS) at the hospital, but tragically, she did not survive.

I was devastated when my wife died after the operation," he said, his voice cracking with emotion. "What's even more painful is that the operation was performed by quack medical personnel with a JCHEW qualification. He was not a qualified doctor, but the hospital allowed him to perform the surgery (KII, 2024).

He alleged that the quack personnel had been an apprentice at the hospital and was not qualified to perform such a complex operation. He claimed that the doctor in charge of the hospital had traveled to Makurdi on the day of the operation and had instructed the quack personnel to carry out the surgery.

This is not an isolated incident," he said, his anger and frustration palpable.

Many husbands have lost their loved ones in this hospital, operated on by the same quack personnel.
It's a scandal, and something needs to be done about it. I reported that he had taken his complaint to Ukan Kurugh, a human rights activist in Benue State. I want justice for my wife's death," he said. I want the hospital to take responsibility for their negligence, and I want the quack personnel to be held accountable for his actions (KII, 2025).

Ukan Kurugh, a renowned human rights activist, made a passionate plea on a media broadcast on March 1, 2025, highlighting the alarming rate of medical errors in Zone A Senatorial District, his home area. He revealed that he had received numerous complaints about medical errors and botched surgical operations in the zone, attributing these incidents to the presence of quack medical personnel who are not qualified to perform operations.
Kurugh emphasized that many hospitals in the area are understaffed, and the few available medical personnel often prioritize their private hospitals over public healthcare facilities. He urgently called on the Governor of Benue State to intervene and address the issue before it's too late. As a vocal advocate for human rights, Kurugh has been at the forefront of promoting social justice and accountability in Benue State. His efforts have included facilitating medical treatments, recovering funds for individuals, and advocating for the rights of vulnerable populations. Kurugh's plea for urgent intervention highlights the need for improved healthcare infrastructure, stricter regulations, and increased accountability in the medical sector to prevent further medical errors and ensure quality healthcare services for the people of Benue State.

Table 3: Patients and Caregivers' Responses on the Knowledge of Medical Error/Negligence as illegal Act

I know of medical errors and negligence and illegal act		
	Frequency	Valid Percent
SD	10	25.0
D	15	37.5
A	10	25.0
SA	5	12.5
Total	40	100.0
I have known that medical personnel make mistakes without knowing of right to seek for legal redress		
	Frequency	Valid Percent
SD	2	5.0
D	5	12.5
A	15	37.5
SA	18	45.0
Total	40	100.0
I notice medical errors while receiving treatment		
	Frequency	Valid Percent
SD	2	5.0
D	4	12.5
A	10	25.5
SA	24	60.0
Total	40	100.0

Source: Field work, 2024

Table 3 presents the responses of patients and caregivers on their knowledge of medical errors and negligence as illegal acts. The first question asked if respondents knew that medical errors and negligence are illegal acts. The results show that only 25% of respondents strongly agree (SA) that they know medical errors and negligence are illegal acts, while another 25% agree (A). However, 37.5% disagree (D) and 12.5% strongly disagree (SD), indicating a significant lack of awareness among patients and caregivers. The second question asked if respondents knew that medical personnel can make mistakes and that they have the right to seek legal redress. The results show that 45% of respondents strongly agree (SA) that they know medical personnel can make mistakes and that they have the right to seek legal redress, while another 37.5% agree (A). This suggests that a significant proportion of patients and caregivers are aware of their rights in the event of medical errors. The third question asked if respondents had noticed medical errors while receiving treatment. The results show that 60% of respondents strongly agree (SA) that they have noticed medical errors, while another 25.5% agree (A). This suggests that medical errors are a common occurrence in healthcare settings, and that patients and caregivers are often aware of these errors. Overall, the findings of this table highlight the need for increased awareness and education among patients and caregivers about medical errors and their rights in healthcare settings.

Crosstab on showing the types of surgery and health facilities in the area

Types of Surgery Operation	Private Health Facilities	Public Health Facilities
Cesarean Operation (CS)	15	3
General Surgery	23	3
Emergency surgery	10	3
All of the above	20	2

Source: Field work, 2024

This crosstab table examines the types of surgery offered at private and public health facilities. A notable observation from the table is that private health facilities offer a wider range of surgical services, including Cesarean Operation (CS), General Surgery, Emergency surgery, and a combination of all these services. In contrast, public health facilities offer limited surgical services, with only 3 facilities offering CS, General Surgery, and Emergency surgery. The table highlights a significant difference in the types of surgery offered by private and public health facilities. Private health facilities offer a more comprehensive range of surgical services, while public health facilities have limited capacity.

V. DISCUSSION OF FINDINGS

The prevalence of medical errors in the area is a significant concern. According to the study, medical errors occur in both private and public health facilities, with a higher prevalence in public health facilities. The study found that 60% of patients in public health facilities experienced medical errors, compared to 40% in private health facilities. This disparity highlights the need for urgent attention to address the root causes of medical errors in public health facilities.

The study identified several factors responsible for the high prevalence of medical errors in public health facilities. One of the primary factors is the lack of qualified healthcare personnel. Public health facilities have a lower proportion of personnel with advanced qualifications, such as BSc in Medicine & Surgery. This lack of qualified personnel may increase the risk of medical errors. Additionally, public health facilities often lack adequate healthcare infrastructure, including equipment and supplies. This can lead to delays in diagnosis and treatment, increasing the risk of medical errors. Moreover, the

study identified several other strong factors contributing to medical errors. One of these is the "get money quick" syndrome among some medical personnel, where the pursuit of financial gain takes precedence over patient care. This can lead to unnecessary procedures, overmedication, and other forms of malpractice.

Another significant factor is the high cost accrued for surgical operations, specifically Caesarean sections (CS). The exorbitant costs associated with CS can lead to delayed or inadequate care, increasing the risk of medical errors. Furthermore, the study found that the availability of quack medical personnel in the area is a major concern. These unqualified individuals often pose as medical professionals, putting patients' lives at risk. Negligence is also a significant factor contributing to medical errors. The study found that many medical personnel in public health facilities are often negligent in their duties, leading to mistakes and oversights that can have devastating consequences.

CONCLUSION

The study on the prevalence of medical errors in the area has revealed a disturbingly high rate of medical errors in both public and private health facilities. The findings indicate that medical errors are a significant concern in the area, with patients in public health facilities being more vulnerable to medical errors. The study has identified several factors contributing to medical errors, including lack of qualified healthcare personnel, inadequate healthcare infrastructure, poor communication and teamwork among healthcare personnel, high cost of healthcare services, presence of quack medical personnel, and negligence and lack of accountability among healthcare personnel. The findings of this study have significant implications for healthcare policy and practice. There is an urgent need for improved healthcare infrastructure, increased funding for healthcare services, and stricter regulations to prevent quack medical personnel from practicing. Additionally, promoting a culture of accountability and transparency among healthcare personnel, improving communication and teamwork among healthcare personnel, and increasing the number of qualified healthcare personnel are essential to reducing the prevalence of medical errors. Ultimately, the study's findings underscore the need for a multifaceted approach to address the prevalence of medical errors in the area. By addressing the root causes of medical errors and implementing strategies to prevent them, it is possible to reduce the prevalence of medical errors and improve healthcare outcomes for patients in the area. Medical errors and negligence can have severe and far-reaching consequences on human security, affecting not only individual patients but also their families, communities, and the broader healthcare system. It is essential to prioritize patient safety, implement evidence-based practices, and promote a culture of transparency and accountability to mitigate these consequences and ensure high-quality, patient-centered care..

RECOMMENDATIONS

Based on the findings of this study, the following recommendations are made:

i. Urgent Attention to Address Staffing Shortages: There is an urgent need to increase the number of qualified healthcare personnel in public health facilities. The government should prioritize the recruitment and training of additional staff to address the current shortages.
ii. Weeding out Quack Medical Personnel: The presence of quack medical personnel in the area is a significant threat to patient safety. The government should take immediate action to identify and remove quack medical personnel from practice.
iii. Doctors with Private Hospitals: Doctors who have private hospitals and are also employed in public health facilities should be held accountable for their absence from work. They should either be sacked or made to be available at all times to attend to patients in public health facilities.
iv. Speedy Policy to Improve Healthcare Delivery: There is a need for a speedy policy to improve healthcare delivery in the area. This policy should prioritize the provision of quality healthcare services, address staffing shortages, and promote accountability among healthcare personnel.
v. Improved Healthcare Infrastructure: The government should prioritize the improvement of

healthcare infrastructure in public health facilities. This includes the provision of modern equipment, adequate supplies, and a clean and safe environment for patients.

vi. Regular Training and Development: Regular training and development opportunities should be provided for healthcare personnel to improve their skills and knowledge.

viii. Patient Safety and Quality of Care: Patient safety and quality of care should be prioritized in all healthcare facilities. This includes the implementation of measures to prevent medical errors, promote patient safety, and improve the overall quality of care.

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