MEDICAL NEGLIGENCE

Medical Negligence and Legal Responsibility for Treatment of Accidents and Gunshot Victims in Nigeria

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Abstract

Medical negligence in Nigeria remains a persistent challenge, particularly in emergency situations involving accident and gunshot victims, where delays or substandard care can result in preventable harm or death. This paper examined the ethical and legal responsibilities of medical practitioners in such emergency care, with a focus on the Nigerian healthcare system. Using a combination of literature review, analysis of statutory provisions, and judicial precedents, the paper investigates the prevalence, causes, and consequences of negligence in emergency treatment. Findings indicate that systemic deficiencies, misinterpretation of laws, and institutional reluctance to act promptly contribute to violations of patients' rights and professional ethnical duties. Notably, delays in treatment despite clear legal mandates, such as the National Health Act 2014 and the Compulsory Treatment and care for Victims of Gunshot Act 2017, highlight a disconnect between law, ethics, and practice. The paper concludes by recommending stricter enforcement of existing laws, measures for strengthening medical accountability, increased public awareness to ensure the protection of accident and crime victims within Nigeria's healthcare system.

Keywords: compulsory treatment; emergency medical care; gunshot victims; legal liability; medical negligence; right of life

1 Introduction

William Osler (1844-1919), often described as the father of modern medicine, was famously quoted to have said:

"The good physician treats the disease the great physician treats the patient who has the disease".

This principle remain central to the practice of medicine worldwide, emphasizing that health care is not only about treating injuries or illnesses, but also about addressing the needs and dignity of the patient as a person. This ethical foundation is deeply rooted in ancient Greek medical philosophy, particularly in the Hippocratic Oath, a centuries-old guide to medical ethics. Composed around the 5th Century BC and attributed to Hippocrates, the oath obliges physicians to apply their knowledge for the benefit of the sick, to abstain from harm, and to act in the best interests of patients irrespective of their social, legal, or moral standing [1]. Central to the Oath are the principles of beneficence (acting in the patient's best interest), non-maleficence (avoiding harm), and impartiality, which collectively impose a moral duty on medical practitioners to provide immediate and necessary care, particularly in emergency situations where life is at risk.

Despite the clarity of these ethical obligations, Nigerian healthcare providers present a contrasting reality. Reports reveal that gunshot and accident victims are faced with significant challenges in

accessing prompt medical care in hospitals and healthcare centers. A major contributing factor is the prevailing practice of requiring injured persons to present a police report before receiving treatment. This requirement is often justified by reference to, or misapplication of, the provisions of the Robbery and Firearms (Special Provisions) Act, Cap R11, LFN 2004 [2].

Historically, medical practitioners have faced harassment, arrest, or interrogation by law enforcement agencies for treating suspected gunshot victims, sometimes being perceived as accomplices to crime. This situation revealed a troubling intersection between medical practice, law enforcement procedures, and the fundamental rights of patients, particularly the right to life and the right to dignity of the human person as guaranteed under the Constitution of the Federal Republic of Nigeria 1999 (as amended) [3]. Such occurrences have raised serious concerns about medical negligence, professional responsibility, and the prioritization of administrative or legal formalities over the preservation of life.

In response to these challenges, the Nigerian legislature enacted the Compulsory Treatment and Care for Victims of Gunshot Act, 2017, which mandates all hospitals, whether public or private, to provide immediate and adequate treatment to gunshot victims without requiring a police report or advance payment [4]. This statutory obligation is further reinforced by the National Health Act, 2014, which prohibits the refusal of emergency medical treatment on any ground [5].

Notwithstanding these legal safeguards, compliance remains inconsistent, and the persistence of treatment refusal or delay continues to expose victims to grave harm while simultaneously placing healthcare providers at risk of civil, criminal, and professional liability. Through an analytical assessment of ethical principles, statutory obligations, and institutional practices.

1.1 Background to medical negligence in healthcare systems

Medical negligence has become an increasingly significant issue within healthcare systems across the world, particularly in contexts where access to timely and adequate medical care determines survival. Patients entrust their lives and well-being to medical practitioners with the expectation that reasonable care, skill, and professional judgment will be exercised in the course of treatment. Where this expectation is breached through acts or omissions that fall below the accepted standard of medical practice, medical negligence arises.

In many healthcare systems, particularly in developing countries such as Nigeria, the occurrence of medical negligence is often linked to systemic failures and structural challenges, including inadequate infrastructure, shortage of trained medical personnel, poor funding, and weak regulatory oversight. These deficiencies have been identified as major contributors to substandard healthcare delivery [6]. Such challenges place immense pressure on medical practitioners and healthcare institutions, thereby increasing the risk of errors, delays, and inadequate care.

These risks are especially pronounced in emergency situations involving accident and gunshot victims, who typically require immediate medical intervention. In such circumstances, delays or failures in treatment expose patients to heightened vulnerability, often resulting from inefficiencies of the practitioners and the institution itself.

1.2 The ethical duty of care owed by medical practitioners

Medical practice is fundamentally grounded in ethical obligations that guide the conduct of healthcare professionals in their interactions with patients. Central to these obligations is the ethical

duty of care, which requires medical practitioners to act in the best interests of patients and to exercise reasonable skill, diligence, and compassion in the provision of medical services.

This duty of care exists irrespective of a patient's background, financial status, or the circumstances under which medical care is sought. It is informed by established principles of medical ethics, including beneficence, non-maleficence, respect for autonomy, and justice. Beneficence obliges medical practitioners to act for the benefit of patients, while non-maleficence requires them to refrain from acts that may cause harm. In emergency situations, where patients may be unconscious or unable to give informed consent, the duty to preserve life and prevent harm often takes precedence over other ethical considerations.

Beyond individual morality, the ethical duty of care owed by medical practitioners is reinforced through professional codes, statutory regulations, and ethical guidelines governing medical practice in Nigeria. Foremost among these is the Medical and Dental Practitioners Act, which regulates the conduct of medical practitioners and establishes the Medical and Dental Council of Nigeria (MDCN) with authority to enforce professional discipline and ethical standards. Pursuant to this Act, the Code of Medical Ethics in Nigeria prescribes the ethical obligations of medical practitioners, including the duty to provide prompt and adequate medical care, particularly in emergency situations, and to prioritize the preservation of human life above all other considerations [7].

In addition, the National Health Act 2014 affirms the obligation of healthcare providers to deliver appropriate and timely medical services and expressly prohibits the denial of emergency treatment on arbitrary grounds. The Act further guarantees patients' rights to humane and dignified treatment within the healthcare system. Collectively, these legal and ethical instruments transform the duty of care from a mere moral expectation into a legally enforceable obligation, such that failure to comply may attract professional sanctions and legal liability where harm results.

1.3 The urgency and sensitivity surrounding accident and gunshot victims

Emergency medical situations represent the clearest tests of professional responsibility within healthcare systems. Accidents and gunshot victims often demand this immediate medical attention. Such emergencies typically involve severe trauma, excessive blood loss, or internal injuries, where even minimal delays in treatment may result in irreversible harm or death. In this context, the ethical obligation to act in the best interest of patients becomes inseparable from the urgency required in emergency medical care.

The urgency associated with these cases is closely tied to the ethical duty of care and the legal obligation to preserve life. Under the Constitution of the Federal Republic of Nigeria 1999, as amended [8], the right to life is guaranteed [9], imposing a corresponding duty on both the state and its institutions to protect life. Medical practitioners, as key actors within the healthcare system, play a critical role in the realization of this right, particularly in emergency situations where patients are unable to protect their own interests. In the case of gunshot victims, the sensitivity of treatment is further heightened by the perceived criminal implications of such injuries. Historically, fears of police involvement, legal scrutiny, or institutional liability have led to delays or outright refusal of treatment in some healthcare facilities. This practice, however, has no legal justification and poses grave ethical and human rights concerns. To address this issue, the Compulsory Treatment and Care for Victims of Gunshot Act 2017 expressly mandates healthcare providers to render immediate treatment to gunshot victims without requiring a police report or other administrative clearance as a precondition for care.

Similarly, accident victims are entitled to prompt emergency medical treatment without discrimination or procedural injury. The National Health Act 2014 reinforces this obligation by prohibiting the denial of emergency medical treatment on arbitrary grounds and affirming patients' right to humane and dignified care. Any delay or refusal in providing emergency treatment to accident or gunshot victims therefore constitutes not only an ethical breach, but may also amount to a violation of statutory, and constitutional duties.

2 Conceptual and theoretical framework

Negligence, in its simplest sense, is fundamentally rooted in tort law and refers to a failure to exercise proper care, resulting in harm to another person. Under Nigerian law, the Supreme Court in U.T.B (Nig) Ltd v Ozoemena [10] described negligence as:

"Lack of proper care and attention; careless behavior or conduct; a state of mind which is opposed to intention; the breach of duty of care imposed by common law and statute resulting in damage to the complainant".

This definition captures the essential elements of negligence as a legal wrong, namely the existence of a duty of care, its breach, and the occurrence of damage resulting from that breach.

Within the medical context, negligence assumes a heightened and specialized dimension due to the peculiar nature of medical practice and the vulnerability of patients. Negligence in law connotes the omission or failure to do something which a reasonable person, guided by the considerations that ordinarily regulate human conduct, would have done, or the doing of something which such a person would not have done under similar circumstances. Where such omission or act results in injury, a cause of action arises. However, in determining professional negligence, the applicable test is not that of the ordinary reasonable person, but that of an ordinary skilled professional exercising and professing to have the relevant expertise [11].

In this regard, anyone who holds himself out as a medical practitioner is duty-bound to exercise the requisite degree of care and skill expected of the profession. The fact that such a practitioner is inexperienced or undergoing training does not diminish this obligation. This position was clearly articulated in Jones v Manchester Corporation [12]. In that case, a trainee anesthetist attempted to apply a nitrous oxide mask to a patient who had sustained facial burns, resulting in sloughing of the patient's facial skin. The trainee thereafter administered two loading doses of barbiturate, which ultimately led to the patient's death. The court rejected the defense of inexperience and held the trainee liable for negligence, apportioning 20% of the damages against him and 80% against his employer. The case underscores the principle that once a person undertakes medical responsibilities, he must meet the professional standard of care, irrespective of his level of experience.

Consequently, healthcare providers are under a legal and ethical obligation to exercise reasonable care, skill, and diligence in the diagnosis, treatment, and overall management of patients entrusted to them. This duty becomes particularly critical in emergency situations, where delay, inaction, or inappropriate intervention can result in irreversible injury or loss of life. The Rules of Professional Conduct for Medical and Dental Practitioners, also known as the Code of Medical Ethics, further codify these obligations and stipulate several instances that would amount to professional negligence. Some of these include:

- Failure to attend promptly to a patient requiring urgent attention when the practitioner was in a position to do so.

- Failure to advise, or proffering wrong advice to a patient on the risk involved in a particular operation or course of treatment, especially if such an operation or course of treatment is likely to result in serious side effects like deformity or loss of organ.
- Failure to obtain the consent of the patient (informed or otherwise) before proceeding on any surgical procedure or course of treatment, when such a consent was necessary.
- Making an incorrect diagnosis or a mistake in treatment e.g., amputation of the wrong limb, inadvertent termination of a pregnancy, prescribing the wrong drug in error for a correctly diagnosed ailment, etc., especially when the clinical features were so glaring that no reasonable skillful practitioner could have failed to notice them.
- Failure to refer or transfer a patient in good time when such a referral or transfer was necessary.
- Manifestation of incompetence in the assessment of a patient.
- Failure to do anything that ought reasonably to have been done under any circumstance for the good of the patient [13].

In medical practice, the relationship between a doctor and a patient embodies both contractual and tortious elements. While informed consent, payment of fees, and the provision of treatment reflect contractual undertones, the overarching obligation to exercise reasonable professional care is grounded in tort. A breach of either obligation may therefore attract civil liability [14].

2.1 Elements of medical negligence

In claims of medical negligence, the burden of proof lies squarely on the patient (or plaintiff) to establish that the healthcare provider failed in the performance of his professional duties and that such failure caused harm. For a claim in medical negligence to succeed, the claimant must prove certain essential elements. These elements largely mirror the general principles of negligence in tort but are applied within the specialized context of medical practice. Nigerian courts have consistently held that the plaintiff must prove, on the balance of probabilities, each constituent element of negligence before liability can be established. These elements, commonly referred to as the “Four Ds”, are: duty of care, dereliction (breach of the applicable standard of care), direct causation, and damages. But only three (3) will be discussed below;

2.1.1 Duty of care

The foundation of the law of negligence was laid by Lord Atkin in the landmark decision of Donoghue v Stevenson [15]. In that case, the plaintiff’s friend purchased a bottle of ginger beer for her at a cafe. After consuming part of the drink, the plaintiff discovered the remains of a decomposed snail floating in the bottle. The shock and ingestion of the contaminated drink resulted in severe gastroenteritis. The case went to the House of Lords to determine whether a manufacturer owed a duty of care to the ultimate consumer, despite the absence of a contractual relationship. Lord Atkin articulated the foundational principle of modern negligence law, recognizing a general duty of care arising from certain relationships. Lord Atkin then laid down the now-famous "neighbor principle" in the following oft-quoted passage:

“You must take care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbor. Who, then, in law is my neighbor? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in contemplation as being so affected when I was directing my mind to the acts or omissions which are called in question”.

Although the principle was articulated in the context of a manufacturer-consumer relationship, it has since been applied as a general test for the existence of a duty of care across a wide range of negligence cases [16].

In the context of medical negligence, the Donoghue v Stevenson principle finds direct application. A patient is clearly a person who is so closely and directly affected by the acts or omissions of a medical practitioner that the practitioner ought reasonably to have the patient in contemplation when making clinical decisions. Accordingly, once a medical practitioner undertakes to diagnose, advise, or treat a patient, a duty of care arises by operation of law [17].

The duty of care owed by a medical practitioner is not reduced by inexperience or trainee status. Any person who holds himself out as a medical professional owes a duty to exercise reasonable care and skill consistent with the standards of the profession [18]. Therefore, the first element of medical negligence is established once it is shown that a medical practitioner or institution undertook responsibility for a patient, thereby creating a legal duty to exercise reasonable care and skill in the patient's treatment and management [19].

2.1.2 Dereliction (breach of the applicable standard of care)

The second element of medical negligence, often referred to as dereliction of duty, arises when a healthcare provider fails to meet the standard of care owed to a patient. This failure may take multiple forms, including misdiagnosis or failure to diagnose, prescribing the wrong medication or dosage, mixing up patients' medical records, committing surgical errors, or causing harm during childbirth through improper techniques [20]. The breach can result from acts of commission, where a practitioner does something incorrectly, or omission, where the practitioner fails to take action that a reasonably competent professional would have undertaken.

The test for breach is objective: a practitioner is considered in breach if a reasonably competent and prudent physician in similar circumstances would not have acted in the same way [21]. Nigerian courts, in line with common law principles, have adopted this standard to assess professional conduct in medical negligence claims.

A central tool for evaluating breach is the Bolam test, established in Bolam v Friern Hospital Management Committee [22]. According to this test, a medical professional is not negligent if their conduct aligns with a practice accepted as proper by a responsible body of medical opinion. However, the courts have refined this standard, clarifying that it is not sufficient for a body of opinion merely to exist; the opinion relied upon must be logical and reasonable [23].

Consequently, acts of manifest incompetence or reckless disregard for patient safety are not protected under the Bolam principle.

In the context of private healthcare, patients may enter contractual relationships with their physicians. While the standard of care remains the same, a doctor who guarantees a specific result may breach the contract if that result is not achieved, regardless of whether negligence is proven. Certain serious errors, such as amputating the wrong limb, may give rise to a rebuttable presumption of negligence, placing the onus on the practitioner to demonstrate that they met the requisite standard of care [24].

2.1.3 Damage arising from breach

Damages constitute the final element in an action for medical negligence. Once a claimant has successfully established the existence of a duty of care, a breach of that duty, and a causal link

between the breach and the injury suffered, the law further requires proof that the claimant has sustained legally recognizable damage. Negligence, however serious, is not actionable in the absence of actual damage.

In medical negligence claims, damage extends beyond mere physical injury. It encompasses physical harm, recognized psychiatric injury, and financial loss arising directly from the negligent act or omission. Psychiatric injury, for this purpose, must be a medically recognized condition such as post-traumatic stress disorder, anxiety disorder, or adjustment disorder. Mere grief, emotional upset, or distress, however profound, does not constitute compensable damage in law [25].

The underlying principle guiding the assessment of damages is *restitutio in integrum*, which requires the court to place the claimant, as far as money can do it, in the position he or she would have occupied had the negligent act or omission not occurred.

The losses suffered by patients in medical negligence cases are broadly classified into pecuniary (economic) and non-pecuniary (non-economic) losses. Pecuniary losses are those capable of precise monetary calculation and include medical and hospital expenses, loss of earnings, costs of rehabilitation, transportation expenses, and the cost of special equipment necessitated by the injury. Non-pecuniary losses, on the other hand, relate to injuries that cannot be accurately quantified in monetary terms. They include pain and suffering, encompassing both physical discomfort and psychological trauma; loss of amenity, being the deprivation of the ordinary pleasures and enjoyment of life resulting from the injury; and loss of consortium, which compensates close family members for the loss of companionship, care, and support occasioned by the injury [26].

2.2 Meaning of gunshot victim under Nigerian law

The concept of a gunshot victim carries both legal and practical significance in Nigeria, particularly within the framework of emergency medical treatment and statutory obligations. While there is no universally accepted definition, the term generally refers to an individual who sustains injury from a gun projectile, potentially resulting in bleeding, fractures, or damage to vital organs [27].

In Nigeria, the Compulsory Treatment and Care for Victims of Gunshot Act, 2017, enacted to provide guidance on the compulsory treatment of gunshot victims, offers the clearest statutory definition. The interpretation section of the Act defines a "victim" as:

"a person who sustains injuries as a result of gunshot, powder burn, and other injuries arising out of or caused by the discharge of a firearm" [28].

It is important to note, however, that the Act does not cover injuries sustained through knives, sharp objects, or other forms of violent attack, which frequently accompany armed robberies and other criminal acts in Nigeria. This omission presents a significant gap in legal protection, as individuals injured in such circumstances may face delays or denial of emergency medical care, despite being in life-threatening situations [29].

The Act imposes clear obligations on hospitals, medical personnel, and security agencies. By defining who qualifies as a victim, the Act clarifies the rights of individuals to immediate medical treatment and shields healthcare providers from harassment or legal reprisal when providing care in compliance with the law. For the purposes of this paper, a gunshot victim is understood as any person who sustains injury directly resulting from the discharge of a firearm. The statutory definition ensures that such individuals are entitled to immediate medical care, while simultaneously protecting doctors and hospitals from interference by law enforcement. This framework enables healthcare providers to

act promptly to save lives, balancing professional duties, ethical obligations, and the constitutional rights of patients. Ultimately, it establishes a clear benchmark for assessing medical negligence, identifying parties to be held liable, and evaluating the consequences of delaying or refusing emergency treatment.

2.3 Emergency medical treatment

According to the International Federation for Emergency Medicine, emergency medical treatment is provided where it is necessary because a person's life or health is in serious danger as a result of disease, injury or ill health [30]. A medical emergency is thus an acute, unforeseen injury or illness that poses an immediate risk to a person's life or long-term health, sometimes described as a situation threatening "life or limb" [31]. Such conditions require prompt intervention to preserve life, prevent further harm, alleviate pain, or reduce distress [32].

Emergency medical care serves three fundamental functions in healthcare: preserving life, preventing further injury, and promoting recovery [33]. It is a critical component of health systems, contributing to the overall health of the population, responding to people's expectations, and providing protection against the consequences of ill-health understanding emergency medical care conceptually establishes the foundation for analyzing professional obligations, ethnical duties and the circumstances under which medical negligence may arise.

2.4 Legal and regulatory framework for the emergency treatment of accident and gunshot victims

The care and treatment of accident and gunshot victims in Nigeria is grounded in specific laws, statutory provisions and regulatory, frameworks that directly or indirectly provide for emergency treatment.

1. **The Constitution of the Federal Republic of Nigeria 1999 (as amended):** The right to healthcare and medical treatment can be deduced Section 33(1) of the 1999 Constitution [34] states that "Every person has a right to life, and no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria". Thus, it is inferable that the right to life can include the right to emergency care, as such treatment is necessary for the preservation of life [35]. Additionally, the right to the dignity of a human person is guaranteed under Section 34 (l)(a) of the Constitution [36], which provides that everyone is entitled to human dignity and no one shall be subjected to torture, inhuman or degrading treatment. It is, therefore, reasonable to conclude that a healthcare worker denying a gunshot victim medical treatment for lack of a police report constitutes degrading treatment and violates the right to human dignity [37]. Definitively, these fundamental rights are binding provisions on all Nigerians and must be upheld by medical practitioners and hospitals as they are justiciable and enforceable in courts of law. For instance, a doctor will be liable for murder if he intentionally kills and deprives a patient of his right to life. In contrast, one of the social objectives which the Nigerian government is expected to guarantee is the health of all citizens and the provision of adequate medical facilities. This is expressly provided for under Section 17(3)(c)(d) of the Constitution [38] which reads "(3) The State shall direct its policy towards ensuring that- (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; and (d) there are adequate medical and health facilities for all persons". However, this provision has been rendered non-justiciable and unenforceable by Section 6(6)(c) of the Constitution [39] which states, among other things, that the judicial powers vested in Nigerian courts shall not extend to any issue or question as to whether any act or omission, law or court

decision conforms with the provisions of Chapter II of the constitution, except as otherwise provided by the constitution. This suggests that patients denied emergency treatment or healthcare services in general cannot legally enforce such rights in courts and seek remedies due to this constitutional limitation on socioeconomic rights. This was evidenced in the Supreme Court decision of Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo [40], where the court affirmed the principle of patient autonomy as it relates to rejecting medical treatment but did not buttress the duty of the State or the private healthcare sector to provide life-saving treatment to patients [41]. The only solution to this legal conundrum is the courts' willingness to interpret the state's duty to provide emergency care as an extension of the right to life and right to human dignity, thereby making it binding and enforceable under law.

However, recent judicial jurisprudence suggests the emergence of a positive shift for the enforceability of healthcare rights in Nigeria as revealed in Odafe v Attorney General of the Federation [42], where the Federal High Court held that failure to provide medical care to prisoners constituted inhuman and degrading treatment. Although this does not relate to the failure of healthcare workers to provide emergency care, it shows the court's willingness to use the power of judicial activism to accord socio-economic rights with the same binding effect as civil rights.

2. **African Charter on Human and Peoples' Rights (Ratification and Enforcement Act), LFN 1990:** The African Charter on Human and Peoples' Rights (ACFIPR) or the 1981 Banjul charter, is the primary human rights treaty for Africa, which cemented the need to recognise and safeguard fundamental human rights in the continent. Nigeria has domesticated and ratified this international treaty into its legal system, making it a binding law only subject to the constitution [43], as established in the case of Abacha v Fawehinmi [44], thereby affirming that such rights contained therein can be invoked in a court of competent jurisdiction. This denotes the right to health has been incorporated into Nigerian law. A key feature of the charter is that it recognises and guarantees both civil rights and socio-economic rights, as enforceable and justiciable. The right to health is specifically provided in Article 14 of the African Charter on Human and Peoples' Right (Ratification and Enforcement Act), which reads: "Every individual shall have the right to enjoy the best attainable state of physical and psychological health; State parties to the present Charter shall take the necessary actions to safeguard the health of their people and to ensure that they receive medical care when they are sick". Thus, a patient who has suffered harm from medical negligence or the wrongful act of a medical practitioner can initiate proceedings under the African Charter of Human and Peoples' Rights, either under the domestic statutory laws of Nigeria or under the Charter itself [45].

3. **The National Health Act (NHA), 2014:** This is a regulatory framework enacted for the development and management of the healthcare system and to set standards for the provision of medical services in Nigeria, and other related matters [46]. The mandatory nature of providing emergency medical care for patients is contained in aforementioned Section 20(1) of the National Health Act, which reads that "a healthcare provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason". Thus, this section prohibits healthcare workers from refusing to give emergency treatment to victims of accidents and gunshot wounds for any reason. In an effort to enforce compliance with this medico-legal duty, Section 20(2) National Health Act provides that "any person who contravenes this section commits an offence and is liable on conviction to a fine of N100,000 or to imprisonment for a period, not exceeding six months, or to both". Therefore, it makes it a punishable offence for hospitals, medical professionals and other health workers to refuse to administer emergency treatment to patients. However, in

Nigerian medical practice, non-compliance with the provisions under section 20 of the NHA remains a common occurrence as various media reports have documented instances where patients were refused immediate medical care due to reasons such as inability to fulfill certain pre-conditions (such as payment), which resulted in casualties that could have been avoided if the law were effectuated [47]. However, the non-justiciability of Chapter II of the 1999 Nigerian constitution implies that although section 20 of the NHA exists, people denied emergency treatment have minimal constitutional backing to base an action for such denial, unless the courts interpret the provision of emergency care as an off-shoot of the enforceable rights to life and human dignity guaranteed under Chapter IV of the 1999 Constitution of Nigeria (as amended) [48].

4. **The Patients' Bill of Rights (2018):** The Patients' Bill of Rights is an instrument which states the collection of rights and responsibilities of patients and the duties of medical professionals in Nigeria. It was launched in 2018 by the Federal Government in collaboration with the Consumer Protection Council and the Federal Ministry of Health [49]. Although it is not a binding and enforceable law, it lays down expected rights of patients in hospitals and health care centres, including the right to timely access to emergency care. This right is contained in Section 7 of the Patients' Bill of Rights, which states that a patient has the right to "receive urgent, immediate and sufficient intervention and care in the event of an emergency, prioritising such needed attention over other factors including cost and payment as well as law enforcement requirements." The effect of this stipulation is that all patients have a right to immediate emergency care, which is not subject to preconditions such as the presentation of a police report before treatment. Reciprocally, a patient has a corresponding obligation to pay for the emergency healthcare he receives after the treatment has been provided.

5. **Regulatory Guidelines:** Medical and Dental Council of Nigeria (MDCN): The Medical and Dental Council of Nigeria is empowered to regulate the medical and dental profession in Nigeria and determine standards and skills which individuals in the profession must possess, and also set a code of conduct to guide the profession under Section 1 of the Medical and Dental Practitioners Act. The council also established the MDCN Code of Ethics, which mandates that doctors attend to emergency cases irrespective of payment and failure to do so amounts to professional malpractice [50]. The MDCN has codified the rules of professional conduct for Medical and Dental Practitioners in its Code of Medical Ethics in Nigeria (2008). The code established the acceptable standard of care for medical and dental practice in Nigeria. In particular, Rule 26-70 of the Code highlights actions that fall under professional misconduct and malpractice, and this list is not all-inclusive [51].

6. **The Nigerian Criminal Code:** The refusal to provide emergency medical care to a person may constitute criminal negligence or even manslaughter under certain circumstances. For instance, Section 303 of the Criminal Code states that "It is the duty of every person who, except in a case of necessity, undertakes to administer surgical or medical treatment to any other person, or to do any other lawful act which is or may be dangerous to human life or health, to have reasonable skill and to use reasonable care in doing such act; and he is held to have caused any consequences which result to the" life or health of any person by reason of any omission to observe or perform that duty." This section proposes that any medical practitioner who carries out a lawful act on a patient must do so without negligence or gross misconduct and will be liable for any harm suffered due to their omission to perform such an act. Therefore, a medical practitioner will be criminally liable for negligence or manslaughter where a patient dies or experiences deterioration to his health based on the practitioner's refusal to administer emergency treatment, especially if his conduct falls under reckless disregard for human life [52]. Similarly, Section 305 of the Criminal Code provides that "When a person undertakes to do any act the omission to do which is or may be dangerous to human

life or health, it is his duty to do that act; and he is held to have caused any consequences which result to the life or health of any person by reason of any omission to perform that duty." It is, therefore, evident that the criminal liability of a medical practitioner for the negligent treatment of an accident or gunshot victim is premised on a contravention of a duty which such practitioner owes to the victim.

7. **Federal Road Safety Commission (Establishment) Act of 2007:** The Federal Road Safety Commission (Establishment) Act is the primary enactment which led to the establishment of the Federal Road Safety Commission (FRSC). One of the body's establishment functions is preventing and minimising accidents on the road [53]. It is an undisputable fact that a predominant amount of medical emergencies are linked to road accidents. A 2024 report from the National Bureau of Statistics revealed that the total number of road traffic crashes in the Second Quarter of 2024 was 2,404, while that of the First Quarter was 2,662 [54]. Hence, in consideration of this fact, the Act authorises members of the FRSC to arrest and prosecute hospitals and/or medical personnel for the rejection of accident victims and to serve such persons with court processes and notice of offence sheets [55].

8. **The Robbery and Firearms (Special Provisions) Act 1990:** This enactment proves instrumental as it contains key provisions for the treatment of gunshot victims that have shaped the current position under Nigerian law. Imperatively, the Act stipulated that it shall be the duty of any person, hospital or clinic that admits, treats or administers any drug to any person, suspected of having bullet wounds to immediately report the matter to the police [56]. Progressively, it states that such listed persons or bodies who fail to abide by the aforementioned provision shall be liable, in the case of an individual, to imprisonment for a term not exceeding five years and in the case of a hospital, or clinic, to a fine of ten thousand naira and the closure of the hospital or clinic [57]. In consideration of this provision, it is crucial to note that the section does not explicitly state that reporting victims of gunshot wounds to the police is a condition precedent to emergency medical treatment. Accordingly, nothing in the Act prevents an individual, hospital or clinic from treating a person suspected of gunshot wounds, as the Act only places a duty and a prerequisite for such person or body to report the event to the police [58]. The aforementioned provisions aim to aid the arrest and detention of criminals with gunshot wounds during the course of their medical treatment. Yet, reports have revealed that it has become a tool used by police officers to outlaw the emergency treatment.given to victims of bullet wounds without prior police notification and approval [59]. This misinterpretation and misapplication of the Act have led to the delayed medical treatment and subsequent death of innocent gunshot victims.

9. **Compulsory Treatment and Care for Victims of Gunshots Act 2017:** The Compulsory Treatment and Care for Victims of Gunshot Act (hereinafter called the Gunshot Act) 2017 is a comprehensive emergency treatment law which was established to provide for and mandate the treatment of and care for gunshot victims. Its enactment was catalysed by the rampant refusal of hospitals to treat gunshot victims without a police report, which was fueled by the misinterpretation of the Robbery and Firearms Act. The Gunshot Act cleared up all misconceptions surrounding the treatment of victims of bullet wounds and the presentation of a police report. In particular, Section 1, Gunshot Act 2017 mandates that "As from the commencement of this Act, every hospital in Nigeria whether public or private, shall accept or receive, for immediate and adequate treatment with or without police clearance, any person with a gunshot wound." This imposes an obligation on all Nigerian hospitals to first treat victims of gunshot wounds before the fulfilment of any other condition. Complementarily, in an effort to ensure that gunshot victims are actually taken to the hospital for treatment, Section 2(1) [60] provides "every person, including security agents shall

render every possible assistance to any person with gunshot wounds and ensure that the person is taken to the nearest hospital for immediate treatment." Essentially, to effect compliance with the Act, it is provided that where a person or authority including any police officer, other security agent or hospital stands by and fails to perform their duty under the Act which leds to the unnecessary death of a patient with gunshot wounds, it is an offence and such person or institution is liable on conviction" to a fine of five hundred thousand naira or imprisonment of five years or both fine and imprisonment [61]. It is significant to note that the Gunshot Act does not waive the duty of reporting incidents of gunshot wounds to the police. Rather, it clarifies the principle that although such a report is legally required, it is not a condition precedent for treatment. This is evidenced by the provisions of Section 3(l) [62], which provides that a hospital, that receives or accepts any person with a gunshot wound for treatment shall report this fact to the nearest police station within two hours of commencing the treatment. Subsequently, the failure of a hospital to report the admission and treatment of a gunshot victim to the police constitutes an offence and the offender is liable on conviction to a fine of hundred thousand naira and every doctor directly concerned with the treatment is equally liable on conviction to a term of six months or a fine of hundred thousand naira or both such fine and imprisonment [63].

2.5 Historical reluctance to treat gunshot victims

Historically, Nigerian hospitals and clinics frequently refused to treat patients presenting with gunshot wounds unless a prior police report was produced. This practice was largely driven by regulatory ambiguities and the pervasive fear among medical practitioners of being implicated in criminal investigations. The reluctance was not rooted in any explicit statutory prohibition against treating gunshot victims, but rather in a cautious, often erroneous interpretation of criminal procedure laws and police directives.

Section 34 of the Criminal Procedure Act [64], imposes a general civic duty on persons to assist police officers where reasonably demanded, including in preventing the escape of persons lawfully authorized to be arrested. This provision states that "*every person is bound to assist a police officer reasonably demanding his aid in the taking or preventing the escape of any other person whom such police officer is authorized to arrest*". However, this duty to assist law enforcement has frequently been misconstrued as imposing a prior obligation on medical practitioners to secure police authorization before rendering emergency medical care to gunshot victims. In practice, this interpretation effectively elevated police involvement above the immediate medical duty to preserve life.

This misinterpretation occurred against a backdrop of heightened insecurity in Nigeria. Recurrent reports in newspapers and other media reflect persistently high rates of armed robbery and violent crime. For instance, Sikiru Abdul-Raheem documents the prevalence of robberies and killings in Katsina State, highlighting incidents where individuals impersonating police officers unleashed terror on civilians [65].

Such reports reinforced the perception that gunshot wounds were almost invariably linked to criminal activity, thereby deepening the suspicion surrounding victims and intensifying institutional fear within healthcare facilities.

As part of broader crime-control strategies, the Nigerian police developed an informal arrangement requiring doctors to notify the police upon the presentation of gunshot injuries. Although notification in itself is not unlawful, this practice gradually evolved into a de facto requirement for "police clearance" before treatment could commence. Consequently, many hospitals treated police authoriza-

tion as a condition precedent to care, rather than a post-treatment reporting obligation. This practice fundamentally distorted the role of medical practitioners, transforming caregivers into quasi-investigators, and subordinating urgent medical intervention to law enforcement processes.

However, this rigid stance has gradually shifted due to legislative reforms, judicial reasoning, and increased awareness of the imperative of timely medical intervention. Contemporary legal and ethical thinking increasingly rejects the notion that medical practitioners should function as extensions of law enforcement agencies, particularly in emergency contexts where delay can be fatal. In this regard, persuasive authority can be drawn from the decision of the Supreme Court of Canada in R v Dyment [66], where La Forest J emphatically stated that *"the primary concern of physicians must be the care of their patients"* and that physicians "*must not be made part of the law enforcement machinery of the state*." Although not binding in Nigeria, this reasoning is instructive, as it articulates a universal principle underlying medical practice: the preservation of human life and the prioritization of patient welfare above external considerations.

This principle is firmly entrenched in international medical ethics. The International Code of Medical Ethics of the World Medical Association mandates that a physician shall always bear in mind the obligation of preserving human life and shall owe patients complete loyalty and the full application of the resources of medical science. Similar obligations are reaffirmed in the Declaration of Geneva [67] and the Statement on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, all of which emphasize that medical professionals must act independently of political, religious, or institutional pressures when human life is at stake.

Nigerian law also complements these ethical obligations. Section 343 of the Criminal Code Act [68] criminalizes rash or negligent acts that endanger human life, thereby extending criminal liability to medical practitioners whose conduct, whether by act or omission, exposes patients to avoidable harm. In addition, section 16 of the Medical and Dental Practitioners Act 2004 provides for disciplinary measures against practitioners whose conduct falls below acceptable professional standards, reinforcing the accountability of doctors who fail to act in life-threatening situations.

Crucially, the practical realities surrounding police reporting further weaken any justification for delaying treatment pending police clearance. Contrary to assumptions that police reporting is a simple civic process, obtaining a police report in Nigeria is often fraught with systemic inefficiencies. Accessing the "nearest police station" can involve significant delays, especially in emergency scenarios, thereby exposing victims to heightened risk of death or permanent injury.

Moreover, it is widely documented that police services, including bail and report issuance, are frequently conditioned on the payment of illegal fees. For instance, Amaize reports a case where a citizen seeking bail for an accused person was compelled to pay N7,000 before any assistance was rendered [69].

Such practices render the requirement of prior police reporting not only impractical but potentially lethal when imposed as a precondition for medical care.

There have also been recurrent reports of police insensitivity to the plight of citizens, even in circumstances involving loss of life [70], further undermining public confidence in law enforcement responsiveness. Where gunshot victims are left untreated while awaiting police notification, the resulting delay may constitute a violation of the constitutional right to life under section 33 of the 1999 Constitution [71]. Additionally, subjecting patients to prolonged pain and suffering due to

bureaucratic hurdles raises serious concerns under section 34 [72], which guarantees the right to dignity of the human person and prohibits torture, inhuman, or degrading treatment.

Accordingly, any institutional policy or practice that prioritizes police clearance over immediate medical intervention not only contradicts medical ethics but also exposes healthcare providers and institutions to constitutional, civil, and professional liability.

Babafemi Odunsi's widely cited scholarly article, "Should the Doctor be a Detective or a Caregiver?" [73] documents that, for decades, Nigerian hospitals treated police reporting as a precondition or care, despite the absence of any express statutory provision mandating such conduct. Odunsi notes that medical practitioners often acted "out of habit and institutional instruction rather than legal obligation", demonstrating how misinformation became normalized within healthcare systems. This misapplication of criminal statutes effectively subordinated patient care to perceived law enforcement duties, with fatal consequences in emergency cases.

3 Treatment of crime victims without police report

The treatment of crime victims without a police report presents unique ethical and legal challenges distinct from those associated with accident victims. Crime victims often suffer injuries resulting from intentional acts such as assault, armed robbery, rape, domestic violence, or kidnapping. These incidents carry significant medico-legal implications, which sometimes lead medical practitioners and hospitals to insist on police reports before rendering treatment. However, the ethical duty to preserve life and alleviate suffering remains paramount, regardless of the legal context surrounding the injury.

Crime victims frequently arrive at medical facilities in states of severe physical and psychological distress. In many cases, they may be unconscious, traumatized, or fearful of interacting with law enforcement authorities. Ethical medical practice requires sensitivity to the vulnerability of such patients. The principle of respect for human dignity demands that healthcare providers prioritize the immediate medical needs of crime victims rather than subjecting them to further distress through administrative barriers [74].

One of the primary ethical justifications for treating crime victims without a police report lies in the principle of beneficence. Beneficence obliges medical practitioners to act positively in promoting the welfare of patients. For crime victims, this includes providing prompt medical treatment to address injuries, prevent complications, and offer psychological support where necessary.

Delaying treatment until a police report is obtained may exacerbate physical injuries and intensify emotional trauma, thereby violating this ethical principle.

From a legal standpoint, crime victims are entitled to the same duty of care as any other patient. The fact that an injury resulted from criminal activity does not diminish the medical practitioner's obligation to provide care. Once a crime victim presents at a hospital seeking treatment, a duty of care arises. This duty is not contingent upon the victim's willingness or ability to report the crime to the police. Any refusal to treat on this basis may therefore amount to medical negligence where harm results.

A particularly sensitive category of crime victims includes survivors of sexual violence. Victims of rape or sexual assault often face intense stigma, fear of retaliation, and emotional trauma. Insisting on a police report before providing medical care may discourage victims from seeking help and expose

them to further harm. Ethical guidelines emphasize the need for compassionate, confidential, and prompt care for survivors of sexual violence, irrespective of whether they have reported the incident to law enforcement [75]. Medical practitioners are encouraged to prioritize treatment and evidence preservation while respecting the autonomy and emotional well-being of the patient.

The insistence on police reports before treating crime victims is often motivated by concerns about legal liability, evidence preservation, and cooperation with criminal investigations. While these concerns are not entirely unfounded, they should not override the primary ethical obligation to provide medical care.

Medical practitioners can document injuries and preserve forensic evidence where appropriate without withholding treatment. In fact, prompt medical intervention often enhances the quality of medico-legal evidence.

In the Nigerian context, societal attitudes toward crime victims, particularly victims of sexual and domestic violence, further complicate the issue. Fear of social stigma, distrust of law enforcement, and cultural barriers often discourage victims from reporting crimes. Requiring a police report before treatment may therefore effectively deny healthcare to those most in need. This practice undermines public health objectives and contradicts ethical commitments to justice and equity in healthcare delivery [76].

The consequences of refusing to treat crime victims without police reports extend beyond individual cases. Such practices contribute to underreporting of crimes, perpetuate cycles of violence, and erode trust in healthcare institutions. From an ethical perspective, healthcare providers have a role to play in creating safe spaces where victims can seek help without fear of judgment or coercion.

Providing medical care without imposing legal conditions is an essential component of this role.

3.1 Challenges confronting the treatment of accident and crime victims

The major challenges confronting the enforcement of medical responsibility in Nigeria reveal that medical negligence is not merely a product of individual professional failure, but the outcome of deeper systemic and institutional weaknesses. Chronic underfunding of the health sector has left many hospitals ill-equipped to meet even basic emergency standards, while inadequate infrastructure and overstretched personnel make compliance with legal duties increasingly difficult in practice.

3.1.1 Lack of awareness of legal obligations

Also compounding is the persistent fear of legal consequences, particularly in cases involving accident and gunshot victims, which has historically encouraged delay, refusal of treatment, and defensive medical practices. Even more troubling is the widespread lack of awareness of existing laws and reforms, as outdated legal assumptions continue to guide medical decision-making despite clear statutory mandates to the contrary. Together, these factors undermine the effective enforcement of medical responsibility, blur lines of accountability, and ultimately place patients especially the most vulnerable at grave risk.

3.1.2 Institutional policies and administrative practices

Some hospitals operate under internal policies that require police reports before treatment; especially in cases involving accidents or violent crimes. These policies are often not grounded in law but persist due to weak regulatory oversight and poor policy review mechanisms.

3.1.3 Fear of police harassment

Medical practitioners sometimes fear being harassed by law enforcement agencies or becoming entangled in criminal investigations after treating crime victims. This fear discourages prompt treatment and encourages defensive practices that prioritize institutional protection over patient welfare.

3.1.4 Financial concerns

Private hospitals, in particular, may delay treatment due to concerns about payment of medical bills. The absence of a police report is sometimes viewed as a risk factor for non-payment, leading hospitals to prioritize financial security over emergency care.

4 Findings

This paper examined the legal, ethical, and institutional framework governing medical negligence in Nigeria, with particular emphasis on emergency medical care and the treatment of accident and gunshot victims. From the analysis of constitutional provisions, statutes, judicial decisions, ethical codes, and empirical reports, the following key findings emerge.

4.1 Medical negligence in Nigeria is anchored in both law and ethics

The paper finds that medical negligence in Nigeria is not governed by a single statute but arises from an interconnected framework of constitutional guarantees, statutory duties, common law principles, and professional ethics. The Constitution of the Federal Republic of Nigeria 1999 (as amended) establishes foundational rights; particularly the right to life and human dignity, which impose obligations on medical practitioners and health institutions. These constitutional norms are further reinforced by statutes such as the National Health Act, the Compulsory Treatment and Care for Victims of Gunshots Act, and the Medical and Dental Practitioners Act, as well as by the Code of Medical Ethics. Together, these instruments create a legally enforceable duty of care owed to patients, especially in emergency situations.

4.2 The right to life operates as the central norm in emergency medical care

A major finding of the paper is that the right to life constitutes the primary constitutional lens through which medical negligence, particularly in emergencies, is assessed. Judicial interpretations and statutory provisions consistently emphasize that medical practitioners and institutions are under a positive obligation to take reasonable steps to preserve life. In emergency contexts, this duty becomes immediate and non-discretionary. The paper reveals that any delay, refusal, or conditional treatment that exposes a patient to avoidable harm may amount to a violation of constitutional rights in addition to professional negligence.

The preservation of the patient's life is the greatest priority of a medical practitioner.

4.3 Emergency standards of care are objective but also apply contextually

The paper finds that the standard of care in emergency medical situations is assessed using an objective test, namely, what a reasonably competent medical practitioner would have done if placed in the same emergency circumstances [77]. This assessment does not demand perfection or the highest possible expertise; rather, it evaluates whether the practitioner acted reasonably, promptly, and competently in light of the urgency of the situation.

At the same time, the law is sensitive to the realities of emergency practice. Factors such as the immediacy of the threat to life, limited time for decision-making, and the availability of medical resources are taken into account when assessing conduct. However, the paper establishes that these pressures do not excuse refusal to treat, unreasonable delay, or abandonment of patients. Institutional policies, administrative bottlenecks, or fear of legal consequences do not lower the standard of care expected where life-saving intervention is reasonably possible. In emergencies, preservation of life remains the overriding obligation.

4.4 Medical negligence often results from systemic failures rather than pure individual fault

Another key finding of the paper is that many instances of negligent outcomes in emergency medical care arise from systemic failures rather than deliberate or reckless misconduct by individual practitioners. Chronic underfunding of the health sector, inadequate emergency infrastructure, shortage of trained personnel, poor working conditions, and delayed emergency response systems significantly impair the delivery of timely and effective care.

The paper reveals that even where medical practitioners are willing to act, institutional deficiencies may prevent them from meeting the required standard of care. This systemic context complicates the attribution of liability and weakens enforcement, as harm frequently results from structural inadequacies rather than isolated professional error. Consequently, accountability mechanisms often struggle to address negligence that is rooted in institutional incapacity.

4.5 Historical institutional practices contributed to preventable deaths

The paper finds that prior to recent legislative reforms, Nigerian hospitals frequently refused to treat gunshot victims without the presentation of a police report. This practice was largely driven by regulatory ambiguity, institutional directives, and fear of being implicated in criminal investigations. As a result, patients with life-threatening injuries were subjected to delays or outright denial of care.

This institutional reluctance contributed to numerous preventable deaths and severe injuries. The paper establishes that such practices were inconsistent with constitutional guarantees of the right to life and human dignity, as well as established principles of medical ethics. Nevertheless, they persisted due to weak enforcement mechanisms and institutional pressure, demonstrating a systemic failure rather than isolated misconduct.

4.6 Legislative reforms have improved the legal position but not practical compliance

The paper also finds that although Nigeria has enacted progressive legislative reforms mandating emergency treatment and protecting patient rights, practical compliance remains uneven. While statutes such as the National Health Act and the Compulsory Treatment and Care for Victims of Gunshots Act clearly prohibit refusal of emergency care, many medical practitioners and hospital administrators remain unaware of these obligations or continue to prioritize institutional policies over statutory duties.

As a result, legal protections often exist more robustly in theory than in practice. This gap between law and implementation limits the effectiveness of legislative reforms in preventing medical negligence and ensuring accountability, particularly in emergency medical contexts.

4.7 Proof of medical negligence remains procedurally challenging

The paper further finds that despite the existence of clear legal principles governing duty of care, breach, and causation, proving medical negligence in Nigeria remains procedurally difficult for patients. Significant challenges include limited access to medical records, inadequate documentation, professional solidarity within the medical community, and weak investigative and regulatory mechanisms.

These barriers often place patients at a disadvantage, particularly in complex medical cases where expert testimony is required to establish breach and causation. Although evidentiary doctrines such as res ipsa loquitur provide relief in obvious cases where negligence is apparent from the nature of the injury, many claims still fail because patients are unable to prove that the practitioner's conduct fell below the accepted standard or that such breach directly caused the harm suffered.

Overall, the findings reveal a significant gap between Nigeria's legal and ethical commitments to patient protection and the realities of emergency medical practice. While the legal framework is increasingly robust, its effectiveness is undermined by systemic weaknesses, institutional unwillingness, and inconsistent enforcement.

5 Recommendations

The persistent misinterpretation of the Robbery and Firearms (Special Provisions) Act by hospitals and law enforcement agencies, particularly the unlawful insistence on police clearance before treatment, necessitated the enactment of the Compulsory Treatment and Care for Victims of Gunshot Act 2017. Despite its clear provisions prioritizing the preservation of life, implementation challenges remain, driven by hospitals' fear of police harassment and widespread ignorance of the law among enforcement agencies. These failures continue to undermine access to emergency medical care and the constitutional right to life. Accordingly, the following recommendations are proposed to address these gaps and strengthen compliance.

1. **Public Awareness and Legal Sensitisation:** Members of the public, as well as healthcare professionals, need to be educated on the emergency healthcare laws and the rights and obligations they provide. The Nigerian government should collaborate with civil societies and social groups to launch a national legal awareness campaign on emergency healthcare rights and laws. This could include translation and interpretation of healthcare laws into local languages and visual representations in waiting rooms and public spaces, and holding broadcast media and social media campaigns nationwide.
2. **Strict Implementation of Emergency Medical Laws:** The emergency medical laws established by the legislature can only be effective if compliance is ensured. Patients should be intentional about the enforcement of their medical rights and should be willing to institute legal actions where such rights are violated by healthcare workers and others. Similarly, law enforcement agencies must ensure they prosecute practitioners who are criminally liable for negligent acts as it relates to the treatment of accident and gunshot victims.
3. **Regulatory Supervisions:** Regulatory institutions such as the Medical and Dental Council of Nigeria (MDCN) should be authorised to investigate, sanction, and publish disciplinary actions against hospitals or practitioners who refuse to administer emergency care. It has also been suggested that there should be a mandatory system for reporting where healthcare facilities are required to document and disclose all cases of denied emergency treatment [78].

4. **Legislative and Constitutional Reform:** A demanding yet profound solution is the reform of the constitutional provisions of socio-economic rights. The right to emergency healthcare treatment should be entrenched among the provisions of Chapter IV of the 1999 Constitution [79] to accord it with unquestionable enforceability in courts. This will solve the issue of uncertainty regarding the nonjusticiability clause in Section 6(6) (c) [80], which has impeded on the enforcement of social and economic rights. This constitutional amendment will be a pivotal step towards raising the standing of medical rights in Nigeria.

5. **Maintain Comprehensive Documentation:** Practitioners should meticulously record all clinical decisions, including interventions, diagnostic procedures, consent (or justification for implied consent), and patient outcomes. Comprehensive documentation serves multiple purposes: it provides transparency, facilitates continuity of care, supports legal compliance, and protects practitioners in cases of alleged negligence. In emergencies, where implied consent is often invoked, clear records demonstrating the rationale, urgency, and proportionality of interventions are critical in justifying actions post facto and minimizing legal disputes.

6. **Continuous Professional Development and Training:** Ongoing training is essential for practitioners to maintain competence in emergency care, ethical decision-making, and medical-legal responsibilities. Training programs should incorporate simulated emergency scenarios, focusing on rapid assessment, triage and intervention strategies. Studies indicate that gaps in skill and awareness contribute significantly to delays and substandard care in critical situation [81]. Structured continuous professional development ensures practitioners are prepared to respond effectively under pressure, reducing errors and reinforcing accountability.

7. **Awareness and Application of Legal and Ethical Frameworks:** Practitioners must remain well-informed about Nigerian statutes and professional codes that govern medical practice, including the National Health Act 2014, Medical and Dental Practitioners Act 2004 (MDPA), and the CTCVG Act 2017. Proactive legal literacy allows practitioners to apply statutory rights and duties consistently, particularly in high-risk or emergency contexts, minimizing preventable harm and legal exposure. Awareness of the Code of Medical Ethics ensures that practitioners act in the patient's best interest, uphold dignity, and avoid external influences; religious, administrative, or personal, that could compromise care.

8. **Develop Internal Accountability and Reporting Mechanisms:** Hospitals should implement systems to monitor compliance with emergency treatment standards and ensure swift investigation of any lapses. Internal audit teams can track response times, treatment outcomes, and adherence to legal and ethical obligations. These mechanisms not only enhance accountability but also reduce institutional liability by demonstrating proactive management and oversight [82].

9. **Increase Budgetary Allocation for Healthcare:** Nigeria's health sector remains chronically underfunded. According to Adewale & Eromonsele [83], federal health expenditure has consistently remained below 6% of the national budget, far below the 15% target of the 2001 Abuja Declaration. Insufficient funding translates directly into dilapidated infrastructure, lack of equipment, staffing shortages, and poor working conditions. Increased budgetary allocation is essential to ensure functional emergency care and reduce preventable deaths.

10. **Strengthen Emergency Medical Services (EMS):** The government should establish a robust, well-resourced national EMS network. Chisom Michael [84] reports that Nigeria has only 0.4 ambulances per 100,000 population, compared to WHO recommendations of 1 per 10,000, leading to preventable deaths in emergency situations. Investment in emergency transport, central dispatch systems, and coordination between hospitals and pre-hospital services is critical. Beyond merely

increasing the number of ambulances, investment must extend to modernizing emergency infrastructure, including equipping ambulances with life-saving devices, establishing central dispatch centers for coordinated response, and training paramedical staff in advanced life support.

6 Conclusion

This paper has examined the evolving landscape of medical negligence in Nigeria, with a focus on emergency care for accident and gunshot victims. While legal frameworks such as the Constitution, the National Health Act 2014, the MDPA 2004, and the Compulsory Treatment and Care for Victims of Gunshots Act 2017 provide clear guidance on the duties, rights, and liabilities of medical practitioners, the challenge lies in translating these laws into consistent, practical enforcement. Moving forward, there is an opportunity to strengthen the link between statutory protections like the right to life and human dignity and everyday clinical practice.

Findings suggest that medical negligence often stems from a mix of individual lapses and systemic shortcomings. By proactively addressing underfunding, infrastructure gaps, and inadequate emergency response systems, Nigeria can create an environment in which even the most resource-constrained practitioners are able to deliver care that meets legal and ethical standards. Reforms such as eliminating unnecessary institutional barriers, historically exemplified by police-report requirements for gunshot victims demonstrate how targeted policy interventions can prevent avoidable deaths.

Proof of negligence remains a procedural challenge, but the development of more transparent investigative mechanisms, better record-keeping, and professional accountability systems can improve enforcement and support patients' claims. Looking ahead, a diverse strategy is essential: practitioners should prioritize patient care, maintain detailed documentation, engage in ongoing professional development, and stay informed of legal and ethical obligations; hospitals must align internal policies with statutory and ethical requirements, strengthen emergency protocols, and invest in staff training; government and policymakers should expand emergency medical services, modernize healthcare infrastructure, and establish coordinated systems that ensure timely and effective patient care.

Ultimately, the future of patient safety in Nigeria depends on harmonizing legal, ethical, and institutional frameworks with practical, well-resourced healthcare systems. By addressing both professional conduct and systemic deficiencies, the country can minimize preventable harm, uphold patient rights, and cultivate a healthcare environment that is trustworthy, resilient, and responsive to the most urgent medical needs.

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