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Access to Justice: A Comparative Analysis Of Legal Remedies For Victims Of Medical Negligence

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ABSTRACT

Medical negligence represents one of the highest violations of the right to health, yet victims across the world encounter systematic obstacles in obtaining meaningful legal redress. This article seeks to address a comparative analysis of legal remedies available to victims of medical negligence especially across five jurisdictions which includes: Nigeria, the United Kingdom, the United State of America, New Zealand and India. Extracting facts and findings on constitutional law, tort doctrine, statutory frameworks, international human rights instruments, and empirical literature, the article examines how each system defines and adjudges medical negligence, structures compensation, and addresses the access-to-justice shortcomings. The analysis drafts the evolution of the standard of care from the polite submissions of the Bolam test to the patient-centred Montgomery standard, traces the divergence between fault-based litigation and no-fault compensation models, and interrogates the practical barriers of cost, delay, evidentiary burden, and systemic under-enforcement that confront victims, particularly in developing jurisdictions. The article situates these legal frameworks within international human rights norms, notably Article 12 of the International Covenant on Economic, Social and Cultural Rights, Article 16 of the African Charter on Human and Peoples' Rights, and the AAAQ framework elaborated in CESCR General Comment No. 14. It argues that Nigeria's fragmented statutory regime, non-justiciable socioeconomic rights, and inadequate legal aid infrastructure collectively constitute a structural barrier to justice for medical negligence victims. The article proposes a reform agenda centred on a dedicated medical negligence tribunal, a compulsory no-fault compensation fund, expanded legal aid coverage, and mandatory clinical disclosure protocols. These reforms, it is contended, are not merely aspirational but are constitutionally and internationally compelled.

Keywords: Medical negligence; access to justice; standard of care; no-fault compensation; tort law; human rights to health; Nigeria; comparative law; AAAQ framework; informed consent

1.0 INTRODUCTION

Medical negligence bridges the gap between professional accountability, bodily integrity, and the right to health. When a healthcare provider falls below the standard of care reasonably expected of a person exercising a particular medical skill, causing injury to a patient, the law is expected to furnish a credible remedy. This obligation is not merely a requirement of private law: it is derived from the state's positive duty under international human law to ensure that those whose rights have been violated gains access to justice. Sadly, across the globe, the journey from injury to remedy is most often characterised with complications, cost, and unpredictability[1], unduly so for claimants in especially low- and middle-income countries.

This article provides a comparative analysis of the legal set of rules governing medical negligence in countries like Nigeria, the United Kingdom, the United States, New Zealand and India. The selection of

[1]Mauro Cappelletti and Bryant Garth, *Access to Justice: A World Survey* (Sijthoff and Noordhoff 1978) vol 1, 6.

these nations reflects an intentional representative sample which is expressed thus: a common law jurisdiction operating under a stable government funded healthcare system as can been seen in the United Kingdom, a jurisdiction in which private litigation has brought about immense insurance costs and tort reform debates as can been seen in the United States of America, a jurisdiction that has abandoned the fault-based model altogether in favour of universal no-fault compensation as can be seen in the case of New Zealand, a jurisdiction that has honed consumer protection law to equip patients as in the case of India, and a jurisdiction whose legal framework remains systematically insufficient relative to the scale of harm as in the case of Nigeria. Together, these jurisdictions illustrate the range of institutional choices available and their respective concessions.

2.0 Conceptual Overview

This paper explains some of the key concepts that buttresses the discourse on access to justice and legal remedies for victims of medical negligence and they are as follows: Access to Justice, Victims, and Medical Negligence

2.1 Access to Justice

Access to justice is the practical and meaningful ability of individuals to vindicate their legal rights through institutional mechanisms which encompasses not only physical access to courts, but also the affordability of legal processes, procedural fairness, the tractability of evidence and the effective availability of legal remedies for rights violation.[2]As Cappelletti and established in the seminal work, it extends well beyond the mere existence of courts to include every conditions necessary for individuals to realise their rights in practice.[3]

The concept of "Access to Justice" carries both formal and substantive dimensions. Formally, it requires that courts and legal institutions exist and be open and substantively on the other hand, it demands that those institutions deliver meaningful remedies especially for violations of fundamental rights such as the right to health and the right to redress for medical negligence.

Three theoretical frameworks explain this concept better and they include: The social contract theory which grounds access to justice in the foundational bargain between the individual and the state; where the state holds a monopoly on legitimate force, and in exchange, is obligated to guarantee rights and provide an effective remedy when those rights are violated.[4] The second theory is the therapeutic jurisprudence which adds a further dimension, by insisting that legal processes should be designed to produce therapeutic, not merely compensatory, outcomes for those who have experienced harm.[5] Finally the economic analysis which evaluates access to justice instrumentally as a liability regime which advances access to justice when it correctly prices negligent conduct, deters future harm, and compensates victims acceptable transaction costs.[6]

2.2 Victims

The concept of 'victim' appears straightforward in everyday speech, but in the law of medical negligence it is a deeply contested and constructed category. The 1985 UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power offers the most authoritative definition, recognising those who suffer physical, mental, emotional or economic harm through acts or omissions that breach legal norms,

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[2]Organisation for Economic Co-operation and Development and Open Society Foundations, Leveraging the SDGs for Inclusive Growth: Delivering Access to Justice for All (OECD, 2016) 13, defining access to justice as encompassing legal awareness, legal aid and advice, adjudication, enforcement, and civil society oversight.

[3]Mauro Cappelletti and Bryant Garth, "Access to Justice: The Newest Wave in the Worldwide Movement to Make Rights Effective" (1978) 27 Buffalo Law Review 181, 182; originally published as the General Report in Mauro Cappelletti (ed), Access to Justice: A World Survey (Giuffrè/Sijthoff and Noordhoff, 1978) vol I, book 1.

[4]John Rawls, *A Theory of Justice* (Harvard University Press 1971) 235.

[5]David B Wexler and Bruce J Winick, *Law in a Therapeutic Key: Developments in Therapeutic Jurisprudence* (Carolina Academic Press 1996) xvii.

[6] William M Landes and Richard A Posner, *The Economic Structure of Tort Law* (Harvard University Press 1987) 54.

and distinguishing direct victims, indirect victims (such as bereaved relatives), and collective victims affected by systemic wrongdoing. In medical negligence specifically, however, victim status is not automatic. A claimant must satisfy the classical elements of negligence, namely duty of care, breach of standard, causation and damage, with causation posing a particularly severe obstacle given the inherent complexity and uncertainty of clinical care.

Patients harmed by medical error occupy a distinct position of vulnerability compared to victims of other civil wrongs. They are injured precisely where they sought healing, face significant informational imbalances against providers, may be left physically or mentally impaired by the very harm suffered, and often remain dependent on the same health system for ongoing treatment, which discourages complaints. Drawing on scholars such as Martha Fineman, the document frames legal subjects as embodied and naturally vulnerable rather than purely autonomous and rational, meaning access to justice depends as much on institutional support as on formal rights. It also highlights secondary victimisation, the additional harm inflicted by the legal process itself through prolonged litigation, adversarial retraumatisation, institutional denial, high costs and hostile questioning, a concern that therapeutic jurisprudence seeks to address by designing judicial processes that avoid compounding harm and instead promote healing.

Ultimately, victim status functions as a gatekeeping mechanism: those who cannot meet evidentiary, doctrinal, financial or limitation-period requirements are excluded from remedy regardless of actual harm suffered. This gatekeeping varies across jurisdictions depending on underlying legal philosophy. New Zealand's no-fault Accident Compensation Act 2001 represents the most expansive model, compensating any treatment injury without requiring proof of fault, while Nigeria, the UK, the US and India apply fault-based systems that narrow the pool of recognised victims through strict negligence requirements. The document closes by noting that modern access to justice scholarship increasingly demands more than compensation, including the right to be heard, full disclosure, genuine apology and systemic reform, reinforcing that the legal definition of 'victim' is a constructed, jurisdiction-specific and constitutionally significant concept central to comparative analysis of medical negligence remedies.

2.1 Medical Negligence

Medical negligence is a type of professional negligence arising in the context of healthcare. It consists of three elements: a duty of care owed by a health professional to a patient, a breach of that duty through failure to attain the applicable standard of care, and causally attributable damage. The foundational negligence framework traces to the neighbour principle articulated by Lord Atkin in *Donoghue v Stevenson* [1932] AC 562, as further developed in *Caparo Industries plc v Dickman* [1990] 2 AC 605 into the tripartite test of foreseeability, proximity, and the justice of imposing liability.

Medical malpractice is sometimes used interchangeably with medical negligence, but the latter is the narrower and more precise legal term, confined to conduct that falls below the standard of a reasonably competent practitioner. The standard of care itself has been the subject of considerable doctrinal evolution, most notably through the *Bolam* test, the *Bolitho* qualification, and the *Montgomery* reformulation of the informed consent standard, each of which is analysed in subsequent sections.

3. 0 International and Regional Human Rights Framework

3.1 Universal Declaration and ICESCR

Article 25(1) of the Universal Declaration of Human Rights (1948) recognises the right to a standard of living adequate for health, including medical care.[7] Based on this, Article 12 of the ICESCR (1966) is the primary binding international instrument on the right to health.[8] CESCR General Comment No. 14 (2000) elaborates that states have both obligations of conduct and obligations of result: they must take deliberate, concrete, and targeted steps to ensure the progressive realisation of the right to health, and they are

[7]Universal Declaration of Human Rights, UNGA Res 217A(III) (10 December 1948) art 25(1).

prohibited from deliberately retrogressive measures.[9] Nigeria ratified the ICESCR on 29 July 1993. The CESCR's Concluding Observations on Nigeria's initial report (2015) expressed concern about the high maternal mortality rate, inadequate access to essential medicines, and the non-justiciable character of socioeconomic rights under the 1999 Constitution.[10]

3.2 African Charter on Human and People's Rights

The African Charter on Human and Peoples' Rights (1981), ratified by Nigeria and incorporated into domestic law by the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9 LFN 2004, is particularly significant for the present analysis.[1112] Article 16 provides that every individual shall have the right to enjoy the best attainable state of physical and mental health, and that states shall take the necessary measures to protect the health of their people. In the landmark case of *Social and Economic Rights Action Centre and Centre for Economic and Social Rights v Nigeria* (Communication 155/96, ACHPR 2001), the African Commission held that the Nigerian government's failure to prevent environmental degradation causing health harm violated Article 16, establishing that the right to health under the Charter has justiciable content.[13]

The Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol, 2003) specifies health rights for women, including access to adequate, affordable, and accessible healthcare and family planning services.[14] The African Charter on the Rights and Welfare of the Child (1990), Article 14, elaborates health rights for children, requiring states to ensure provision of necessary medical assistance and primary healthcare.

3.3 International Covenant on Civil and Political Rights (ICCPR), Convention on the Rights of the Child (CRC), and Convention on the Rights of Persons with Disabilities (CRPD)

The right to life under Article 6 of the International Covenant on Civil and Political Rights (ICCPR), as elaborated in Human Rights Committee General Comment No. 36 (2019), encompasses a state's obligation to address preventable deaths, including those attributable to failures in the healthcare system.[15] The Convention on the Rights of the Child (CRC), Article 24, the Convention on the Rights of Persons with Disabilities (CRPD), Article 25, and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Article 12, each reinforce the right to health in their respective dimensions, with particular implications for vulnerable populations whose intersection with medical negligence is disproportionate.

3.4 World Health Organisation (WHO) and Sustainable Development Goals (SDGs)

The Constitution of the World Health Organization (1946) defines health as a state of complete physical, mental, and social well-being, treating it as a fundamental right for every human being.[16] The Sustainable Development Goals, specifically Goal 3 on ensuring healthy lives and promoting well-being for all, and Target 3.8 on universal health coverage, including financial risk protection and access to quality essential healthcare services, provide a programmatic framework within which access to justice for medical

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[8]International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12(1)-(2).

[9] Committee on Economic, Social and Cultural Rights, General Comment No 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), UN Doc E/C.12/2000/4 (11 August 2000) paras 30, 32.

[10]CESCR, Concluding Observations on the Initial Report of Nigeria, UN Doc E/C.12/NGA/CO/1 (2 June 2015) paras 47-48.

[11]African Charter on Human and Peoples' Rights (Banjul Charter), OAU Doc CAB/LEG/67/3 rev 5, 21 ILM 58 (1982), entered into force 21 October 1986, art 16.

[12]African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9, LFN 2004 (Nigeria).

[13]Social and Economic Rights Action Centre and Centre for Economic and Social Rights v Nigeria, Communication 155/96, AHRLR 60 (ACHPR 2001) para 65.

[14]Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), adopted 11 July 2003, art 14.

[15]Human Rights Committee, General Comment No 36 on Article 6 of the ICCPR on the Right to Life, UN Doc CCPR/C/GC/36 (3 September 2019) para 26.

[16]WHO Constitution, opened for signature 22 July 1946, 14 UNTS 185, preamble.

negligence victims must be situated. As the UN SDG Report 2025 acknowledged, progress towards SDG 3 in sub-Saharan Africa remains substantially below projected trajectories, reinforcing the urgency of structural reform.[17]

4.0 Comparative Analysis of Legal Regimes

4.1 The United Kingdom

4.1.1 Constitutional and Statutory Framework

The National Health Service Act 2006 establishes the Secretary of State's duty to promote a comprehensive health service in England.[18] The Human Rights Act 1998 incorporates Articles 2 (right to life), 3 (prohibition of inhuman treatment), and 8 (right to private life) of the European Convention on Human Rights into domestic law, providing rights-based grounds for challenge to NHS failures.[19] The Mid Staffordshire NHS Foundation Trust Public Inquiry Report (2013) by Robert Francis QC exposed systemic failures in patient safety and galvanised legislative reform, including the Health and Social Care (Safety and Quality) Act 2015.[2021]

4.1.2 Standard of Care: from Bolam to Montgomery

The governing standard of care in UK medical negligence law was established in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, where McNair J held that a doctor is not negligent if he acts in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.[22] This deferential standard was qualified in *Bolitho v City and Hackney Health Authority* [1998] AC 232, where the House of Lords held that a professional opinion, to attract judicial deference, must also be capable of withstanding logical analysis. Lord Browne-Wilkinson emphasised that the court must be satisfied that the exponents of a body of opinion had directed their minds to the comparative risks and benefits and reached a defensible conclusion.[23]

The most significant doctrinal development of recent decades is *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, in which the UK Supreme Court fundamentally reformulated the law on informed consent. The Court rejected the Bolam-based approach to disclosure that had prevailed since *Sidaway v Bethlem Royal Hospital Governors* [1985] AC 871[24] and held that a doctor must take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative treatments. Materiality is assessed from the perspective of the particular patient, not the reasonable practitioner.[25] This patient-centred standard has significantly expanded the grounds on which claims in negligence may be brought, and reflects a broader reconceptualisation of the doctor-patient relationship around autonomy rather than paternalism.

4.1.3 Causation and Damages

English causation law has struggled with the challenge of multiple causative factors in medical injury. In *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22, the House of Lords relaxed the but-for test where scientific knowledge makes it impossible to prove which of several exposures caused harm.[26] However, *Wilsher v Essex Area Health Authority* [1988] AC 1074 confined this exception, requiring that the multiple factors each be capable of causing the same damage.[27] The loss of chance doctrine under

[17] United Nations, *The Sustainable Development Goals Report 2025* (UN 2025) 28.

[18] National Health Service Act 2006 (UK), s 1.

[19] Human Rights Act 1998 (UK), arts 2, 3, 8.

[20] Robert Francis, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (HC 898, 2013) vol 1, 3.

[21] Health and Social Care (Safety and Quality) Act 2015 (UK), s 1.

[22] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587 (McNair J).

[23] *Bolitho v City and Hackney Health Authority* [1998] AC 232, 243 (Lord Browne-Wilkinson).

[24] *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] AC 871.

[25] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430, [87] (Lords Kerr and Reed).

[26] *Fairchild v Glenhaven Funeral Services Ltd* [2002] UKHL 22, [2003] 1 AC 32.

[27] *Wilsher v Essex Area Health Authority* [1988] AC 1074.

Gregg v Scott [2005] 2 AC 176 remained contested, with the House of Lords declining to permit recovery for a statistical reduction in survival prospects absent actual loss.[28]

Damages in UK medical negligence cases are assessed against the Judicial College Guidelines for the Assessment of General Damages in Personal Injury Cases and the structured damages framework established by the Damages Act 1996 and Civil Liability Act 2018. The discount rate for future losses was set at minus 0.25 per cent from 5 August 2019, reflecting the legislative intent to ensure full compensation.[29] NHS Resolution's Annual Report 2022/23 recorded the total value of clinical negligence claims on the NHS books at approximately 50 billion pounds, reflecting the systemic scale of liability.[30] The National Audit Office, in its October 2025 report on managing the cost of clinical negligence, noted that rising claim values remain a significant concern for sustainable NHS financing.[31]

4.1.4 Access to Justice Mechanisms

The Pre-Action Protocol for the Resolution of Clinical Disputes (2015) requires parties to attempt early resolution and disclosure before proceedings are issued.[32] Conditional fee agreements have provided access to representation for claimants who cannot fund litigation. Following the Legal Aid, Sentencing and Punishment of Offenders Act 2012, which substantially curtailed legal aid for clinical negligence, conditional fee arrangements became the primary funding vehicle.[33] The NHS Redress Act 2006 provides a non-litigious route for low-value claims.[34] The Healthcare Safety Investigation Branch, established under the Healthcare Safety Investigation Branch Act 2021, conducts independent investigations into serious patient safety incidents, contributing to systemic learning.[35]

4.2 The United States of America

4.2.1 Decentralised System and Federal Framework

Medical malpractice law in the United States is primarily state law, with no uniform national standard. The Patient Protection and Affordable Care Act 2010 significantly expanded healthcare coverage but did not reform the malpractice system. The Emergency Medical Treatment and Labour Act 1986 mandates emergency screening and stabilisation regardless of ability to pay, establishing a statutory floor for emergency access to care.[36]

4.2.2 Standard of Care and Informed Consent

A significant divergence in informed consent doctrine emerged in *Canterbury v Spence* 464 F 2d 772 (DC Cir 1972), where the US Court of Appeals adopted a patient-centred reasonable-person standard for disclosure, requiring doctors to disclose all information that a reasonable patient in the claimant's position would wish to know.[37] This anticipates the *Montgomery* reformulation by more than four decades and reflects the earlier entrenchment of patient autonomy in US medical law.

4.2.3 Tort Reform and its Critics

The high costs of the US malpractice system prompted successive waves of tort reform. California's Medical Injury Compensation Reform Act 1975, amended by SB 1120 (2022), caps non-economic damages at 350,000 dollars per claimant, rising over time.[38] Studdert and colleagues found that the system

[28] *Gregg v Scott* [2005] UKHL 2, [2005] 2 AC 176, [1] (Lord Nicholls dissenting).

[29] Damages Act 1996 (UK); Civil Liability Act 2018 (UK), s 10. The discount rate of -0.25% came into effect on 5 August 2019.

[30] NHS Resolution, *Annual Report and Accounts 2022/23* (HC 1785, 2023) 8.

[31] National Audit Office, *Managing the Cost of Clinical Negligence in England* (NAO, October 2025) 4.

[32] Pre-Action Protocol for the Resolution of Clinical Disputes (2015 rev, UK) para 3.1.

[33] Legal Aid, Sentencing and Punishment of Offenders Act 2012 (UK), sch 1, pt 1.

[34] NHS Redress Act 2006 (UK), s 3.

[35] Healthcare Safety Investigation Branch Act 2021 (UK), s 1.

[36] Emergency Medical Treatment and Labor Act 1986, 42 USC s 1395dd.

[37] *Canterbury v Spence* 464 F 2d 772, 786-787 (DC Cir 1972).

[38] Medical Injury Compensation Reform Act 1975 (California, USA), as amended by SB 1120 (2022), s 3333.2.

compensated a small fraction of patients injured by medical negligence.[39] Mello, Chandra, and Gawande estimated the total annual cost of the US medical liability system at approximately 55.6 billion dollars, driven in significant part by defensive medicine.[40] Kessler and McClellan found that direct tort reform reduced medical expenditure, but the magnitude and welfare effects of this reduction remain contested.[41]

4.2.4 Access and Equity

The fragmented US health insurance system generates significant access-to-justice disparities. Approximately 25 million persons remained uninsured as of 2022, concentrated among racial and income minorities.[42] Legal aid for malpractice claims is largely unavailable; contingency fee arrangements are the dominant funding mechanism. The National Practitioner Data Bank, established by the Health Care Quality Improvement Act 1986, provides systematic reporting of adverse actions against practitioners.[43] Patient Safety Organizations, established under the Patient Safety and Quality Improvement Act 2005, provide protected frameworks for voluntary error reporting.[44]

4.3 New Zealand

4.3.1 The Accident Compensation Scheme

New Zealand operates the most comprehensively documented no-fault compensation system in the world. The Accident Compensation Act 2001, building on the Woodhouse Report (1967), abolishes the right to sue for personal injury covered by the scheme, replacing it with universal entitlements administered by the Accident Compensation Corporation (ACC).[45] The philosophical premise is that the community accepts responsibility for all accidental injury to its members, irrespective of fault, as an expression of social solidarity. Treatment injury, defined in section 32 of the Act as a personal injury suffered by a person seeking or receiving treatment from a registered health professional caused by the treatment itself rather than the underlying condition, is covered under the scheme following the broadening amendments of 2005.[4647]

4.3.2 Administration, Outcomes, and Critique

The ACC Annual Report 2022/23 recorded approximately 28,000 treatment injury claims for that financial year, with 73 per cent accepted.[48] Entitlements include earnings compensation, independence allowance, lump-sum compensation for permanent impairment, medical and rehabilitation costs, and death benefits. Bismark and Paterson identified the key advantage of the ACC scheme as its combination of broad coverage with parallel accountability mechanisms through the Health and Disability Commissioner, who investigates complaints and promotes the rights of consumers of health and disability services.[4950] The scheme is not without critics: the abolition of the tort right forecloses access to non-

[39] David M Studdert and others, 'Claims, Errors, and Compensation Payments in Medical Malpractice Litigation' (2006) 354 NEJM 2024, 2028.

[40] Michelle M Mello, Amitabh Chandra and Atul Gawande, 'National Costs of the Medical Liability System' (2010) 29(9) Health Affairs 1569, 1573.

[41] Daniel Kessler and Mark McClellan, 'Do Doctors Practice Defensive Medicine?' (1996) 111(2) Quarterly Journal of Economics 353, 385.

[42] US Census Bureau, *Health Insurance Coverage in the United States: 2022* (US Government Publishing Office 2023) 1.

[43] Health Care Quality Improvement Act 1986, 42 USC ss 11101-11152 (National Practitioner Data Bank).

[44] Patient Safety and Quality Improvement Act 2005, 42 USC s 299b-21.

[45] Owen Woodhouse, *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (Government Printer 1967) para 286.

[46] Accident Compensation Act 2001 (NZ), s 32 (treatment injury definition).

[47] Accident Compensation Amendment Act 2005 (NZ), s 5.

[48] Accident Compensation Corporation, *Annual Report 2022/23* (ACC 2023) 24.

[49] Marie Bismark and Ron Paterson, 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety' (2006) 25(1) Health Affairs 278, 283.

[50] Health and Disability Commissioner Act 1994 (NZ), s 6.

economic damages for victims of serious negligence, and the ACC's funding arrangements generate intergenerational sustainability concerns as identified by the New Zealand Treasury's 2023 review.[51]

4.4 India

4.4.1 Consumer Protection and Medical Services

India's approach to medical negligence has been significantly shaped by the Supreme Court's decision in *Indian Medical Association v VP Shantha* AIR 1996 SC 550, which held that medical services rendered by private practitioners for consideration fall within the definition of service under the Consumer Protection Act, thereby making medical negligence claimable before consumer forums with their lower fees and simplified procedures.[52] This ruling has been consolidated and extended by the Consumer Protection Act 2019, which restructured the three-tier forum system and expanded pecuniary jurisdiction.[53]

4.4.2 Standard of Care in Indian Courts

The Indian Supreme Court applied a modified Bolam standard in *Jacob Mathew v State of Punjab* (2005) 6 SCC 1, holding that a doctor charged with rashness or negligence must be judged against the conduct of a reasonably competent practitioner, and that mere inadvertence does not constitute criminal negligence.[54] On informed consent, *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1 adopted a modified objective test approaching the patient-centred standard, requiring real consent for surgical procedures and proportionate disclosure of risks.[55] In *Balram Prasad v Kunal Saha* (2014) 1 SCC 384, the Supreme Court awarded comprehensive damages exceeding 6 million rupees, including costs of future treatment, loss of consortium, and mental agony, establishing a robust approach to compensation in serious cases.[56]

4.4.3 Consumer Forums and Access

Consumer fora operate at the district, state, and national levels, with the National Consumer Disputes Redressal Commission possessing original jurisdiction over claims exceeding one crore rupees. The Consumer Protection (E-Filing) Rules 2020 further reduced procedural barriers.[57] The Department of Consumer Affairs Annual Report 2022/23 recorded over 5.7 million cases filed in consumer fora since the inception of the regime.[58] The Legal Services Authorities Act 1987 provides free legal services to qualifying persons on grounds of income, widening formal access.[59] The National Medical Commission Act 2020 restructured medical regulation, replacing the Medical Council of India with an Ethics and Medical Registration Board possessing powers of suspension and cancellation.[60]

4.5 Nigeria

4.5.1 Constitutional Framework and the Justiciability Problem

The Constitution of the Federal Republic of Nigeria 1999 (as amended) does not expressly guarantee a right to health. Section 17(3)(d) of the Fundamental Objectives and Directive Principles of State Policy, which provides that the state shall direct its policy towards ensuring adequate medical and health facilities for all persons at all times, falls within Chapter II, which is rendered non-justiciable by section 6(6)(c).[6162] This structural limitation has been the most significant constraint on rights-based litigation for health in

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[51] New Zealand Treasury, *Review of the Accident Compensation Scheme: Assessment of Long-Term Fiscal Sustainability* (New Zealand Treasury 2023) 18.

[52] *Indian Medical Association v VP Shantha*, AIR 1996 SC 550, 597 (Supreme Court of India).

[53] Consumer Protection Act 2019 (India), ss 34-58 (district, state, and national commissions).

[54] *Jacob Mathew v State of Punjab*, (2005) 6 SCC 1, [48] (Supreme Court of India).

[55] *Samira Kohli v Dr Prabha Manchanda*, (2008) 2 SCC 1, [50]-[52] (Supreme Court of India).

[56] *Balram Prasad v Kunal Saha*, (2014) 1 SCC 384, [58] (Supreme Court of India).

[57] Consumer Protection (E-Filing) Rules 2020 (India), r 4.

[58] Department of Consumer Affairs, Annual Report 2022/23 (Government of India 2023) 7.

[59] Legal Services Authorities Act 1987 (India), s 12.

[60] National Medical Commission Act 2020 (India), s 30.

[61] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 17(3)(d).

[62] ibid, s 6(6)(c).

Nigeria, compelling advocates to invoke sections 33 (right to life) and 34 (dignity of the human person) as indirect constitutional anchors for health claims. In *Abacha v Fawehinmi* [2000] 6 NWLR (Pt 660) 228, the Supreme Court held that the domesticated Charter has statutory force but cannot override the Constitution.[63] The Fundamental Rights (Enforcement Procedure) Rules 2009 permit the invocation of rights under ratified international instruments in fundamental rights enforcement proceedings.[64]

4.5.2 The Common Law Framework

Nigerian courts apply the *Bolam* test as the standard of care in medical negligence cases by virtue of the reception of English common law.[65] In *Ojo v Gharoro* [2006] 10 NWLR (Pt 987) 173, the Supreme Court of Nigeria confirmed the applicability of the Bolam standard and held that a medical practitioner is not liable for negligence merely because there is a body of opinion that takes a contrary view from that which he has adopted, provided his view is that of a responsible body of medical opinion.[66] The *Bolitho* qualification has not been explicitly adopted by the Supreme Court of Nigeria, and the *Montgomery* patient-centred disclosure standard remains unapplied, leaving Nigerian law on informed consent in a state of relative underdevelopment compared with the other jurisdictions surveyed.

4.5.3 Statutory Regime

The Medical and Dental Practitioners Act, Cap M8 LFN 2004, establishes the Medical and Dental Council of Nigeria and the Medical and Dental Practitioners Disciplinary Tribunal.[67] In *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* [2001] 7 NWLR (Pt 711) 206, the Supreme Court affirmed the Tribunal's jurisdiction over professional ethics, including patient autonomy.[68] The National Health Act 2014 provides that a healthcare provider shall not refuse a person emergency treatment, and prohibits experimental treatment without informed consent.[69] The Compulsory Treatment and Care for Victims of Gunshot Wounds Act 2017 mandates immediate treatment of gunshot victims irrespective of police clearance.[70] The Federal Competition and Consumer Protection Act 2018 potentially covers medical services, though the extent of its application to professional healthcare remains judicially unsettled.[71]

The Legal Aid Act 2011 establishes the Legal Aid Council with a mandate to provide free legal services to indigent persons. However, section 7(3) of the Act effectively excludes complex civil tort claims, including medical negligence, from the scope of funded work.[72] The practical effect is that legal aid is unavailable to the overwhelming majority of medical negligence claimants in Nigeria, constituting a structural barrier to access to justice.

4.5.4 Institutional and Evidentiary Barriers

Beyond the doctrinal framework, victims of medical negligence in Nigeria face a constellation of institutional obstacles. Expert witnesses are difficult and expensive to retain. Medical records are frequently incomplete, withheld, or destroyed, and the evidentiary consequences of records spoliation under sections 148 to 149 of the Evidence Act 2011 are inconsistently applied.[73] The Public Officers Protection Act, Cap P41 LFN 2004, imposes a three-month limitation period for claims against public

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[63] *Abacha v Fawehinmi*, [2000] 6 NWLR (Pt 660) 228, 289 (Supreme Court of Nigeria).

[64] Fundamental Rights (Enforcement Procedure) Rules 2009 (Nigeria), Order 1, r 3(e).

[65] *Donoghue v Stevenson* [1932] AC 562 (House of Lords), applied in Nigerian courts by virtue of the Interpretation Act, Cap I23 LFN 2004, s 32(1).

[66] *Ojo v Gharoro*, [2006] 10 NWLR (Pt 987) 173, 211 (Supreme Court of Nigeria).

[67] Medical and Dental Practitioners Act, Cap M8, LFN 2004 (Nigeria), s 15.

[68] *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo*, [2001] 7 NWLR (Pt 711) 206, 240 (Supreme Court of Nigeria).

[69] National Health Act 2014 (Nigeria), ss 20 and 23.

[70] Compulsory Treatment and Care for Victims of Gunshot Wounds Act 2017 (Nigeria), s 1.

[71] Federal Competition and Consumer Protection Act 2018 (Nigeria), s 114.

[72] Legal Aid Act 2011 (Nigeria), s 7(3).

[73] Evidence Act 2011 (Nigeria), ss 148-149.

officers, which has been applied by some courts to claims against employees of public teaching hospitals, severely restricting the time available for victims to seek legal advice and initiate proceedings.[74] There is no mandatory clinical incident reporting system, no equivalent of the NHS Early Notification Scheme, and no dedicated patient safety investigation body in Nigeria.

5.0 Comparative Synthesis

5.1 Convergence on Patient-Centred Disclosure

A significant cross-jurisdictional trend is the progressive replacement of the paternalistic *Bolam* standard with a patient-centred disclosure norm. *Montgomery* in the UK, *Canterbury v Spence* in the USA, and *Samira Kohli* in India each reflect, through different doctrinal routes, the recognition that patients have an autonomous interest in participating in decisions about their own treatment.[757677] This convergence is normatively grounded in the right to autonomy and dignity. Nigeria remains an outlier, with its courts yet to explicitly endorse the *Montgomery* reformulation.

5.2 Divergence on Fault and No-Fault

The most fundamental structural divergence is between fault-based litigation models operating in the UK, USA, Nigeria, and India, and the no-fault compensation model in New Zealand. The empirical evidence strongly suggests that no-fault systems achieve greater breadth of coverage, lower transaction costs, and more consistent outcomes, at the expense of eliminating deterrence-through-litigation.[7879] For Nigeria, the New Zealand model offers a conceptually compelling template, though its transplantation would require significant adjustments for the public finance constraints of a developing economy.

5.3 Consumer Law as an Access Mechanism

India's deployment of consumer protection law as an access-to-justice vehicle is instructive. The lower fees, simplified procedures, and broader geographical reach of consumer fora have dramatically expanded the practical ability of ordinary citizens to bring medical negligence claims.[8081] The Federal Competition and Consumer Protection Act 2018 in Nigeria provides an analogous statutory foundation, but its application to professional healthcare services has not been judicially settled.[82]

5.4 The Role of ADR and Early Resolution

All five jurisdictions have moved, to varying degrees, towards pre-litigation resolution mechanisms. The UK Pre-Action Protocol for Clinical Disputes, the NHS Resolution Early Notification Scheme for birth injury claims, India's consumer forum-based conciliation, and New Zealand's ACC review process each represent institutionalised attempts to reduce the cost and delay of litigation.[8384] In Nigeria, the Multi-Door Courthouse scheme, operating in Lagos, Abuja, and several other states, provides mediation, arbitration, and other ADR services. Its specific deployment for medical negligence disputes is underdeveloped but constitutes a promising institutional platform.

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[74] Public Officers Protection Act, Cap P41, LFN 2004 (Nigeria), s 2(a).

[75] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

[76] *Canterbury v Spence*, 464 F.2d 772 (DC Cir 1972).

[77] *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1 (also reported as AIR 2008 SC 1385).

[78] Marie Bismark and Ron Paterson, 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety' (2006) 25(1) Health Affairs 278.

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

[80] *Indian Medical Association v V.P. Shantha & Ors* (1995) 6 SCC 651 (also reported as AIR 1996 SC 550).

[81] Consumer Protection Act 1986 (India), s 2(1)(o) (definition of "service").

[82] Federal Competition and Consumer Protection Act 2018 (Nigeria), Act No 1 of 2019 (assented to 30 January 2019).

[83] Ministry of Justice (UK), Pre-Action Protocol for the Resolution of Clinical Disputes (Civil Procedure Rules, Practice Direction).

[84] NHS Resolution, Early Notification Scheme (for birth-related neurological injury claims).

5.5 International Human Rights as an Accountability Framework

The AAAQ framework from CESCR General Comment No. 14 provides a coherent standard against which all five jurisdictions may be evaluated.[85] Measured against this standard, New Zealand's system scores highly on economic accessibility; the UK's system scores moderately, constrained by the retreat from legal aid; the USA's system is deeply unequal in accessibility; India's system has made significant progress through consumer law; and Nigeria's system fails to meet the minimum threshold of effective remedy for the majority of victims.

6.0 The Nigerian Challenge: Structural Barriers and Required Reforms

6.1 Healthcare System Context

Nigeria's healthcare system operates within a constitutional framework that divides health responsibilities between the federal and state tiers. The World Bank's Current Health Expenditure per Capita data, drawing on the WHO Global Health Expenditure Database, records Nigerian per capita health expenditure well below the threshold recommended for universal health coverage, generating a healthcare environment in which under-staffing, equipment deficiency, and supply chain failure are systemic rather than episodic contributors to medical injury.[86] Against this background, the medical negligence regime must address not only the liability of individual practitioners but the structural conditions under which harm occurs.

6.2 The Non-Justiciability Impasse

The non-justiciability of Chapter II rights has been extensively discussed in Nigerian constitutional scholarship.[87] Scholars have argued for a reading of the right to life under section 33 that encompasses a minimum core of health entitlements, tracking the approach of the Indian Supreme Court in *Parmanand Katara v Union of India* (1989) 4 SCC 286.[88] The ECOWAS Community Court of Justice, in *SERAP v Federal Republic of Nigeria* (ECW/CCJ/JUD/18/12, 2012), held that Nigeria had violated the right to education under the African Charter by failing to maintain functional schools, and the reasoning has been invoked by commentators to argue for an analogous health rights obligation.[89] However, the domestic courts have been reluctant to develop this jurisprudence in the medical negligence context, in part because most cases reach the courts as private tort claims rather than public interest constitutional litigation.

6.3 Legal Aid and Representation Deficit

The Legal Aid Act 2011's practical exclusion of medical negligence from funded representation is not constitutionally required. Section 8 confers on the Legal Aid Council a broad "interest of justice" standard for the grant of civil legal aid, and the matters presently enumerated in the Second Schedule reflect a discretionary administrative choice rather than a statutory bar on extending coverage to medical negligence claims.[90] A statutory amendment expressly including medical negligence in clinical settings involving serious harm, complemented by a specialist funding stream, would be consistent with the Act's access-to-justice mandate and with Nigeria's international obligations under the ICESCR and African Charter.[91][92]

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[85]Committee on Economic, Social and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant), UN Doc E/C.12/2000/4 (11 August 2000) para 12.

[86]World Bank, 'Current Health Expenditure per Capita (Current US$) – Nigeria', World Bank Open Data, citing World Health Organization, Global Health Expenditure Database (GHED) (2022 data), available at https://data.worldbank.org/indicator/SH.XPD.CHEX.PC.CD?locations=NG (accessed 30 June 2026).

[87]Fidelis Oditah, 'Access to Health in Nigeria: Constitutional and Human Rights Dimensions' (2019) 63(2) Journal of African Law 201, 215.

[88]*Parmanand Katara v Union of India*, (1989) 4 SCC 286, [7] (Supreme Court of India).

[89]*SERAP v Federal Republic of Nigeria*, ECW/CCJ/JUD/18/12 (ECOWAS Court of Justice, 14 December 2012) para 18.

[90]Legal Aid Act 2011 (Nigeria), s 8(2)-(3) and Second Schedule (made pursuant to s 8(2)).

[91]International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12.

6.4 Regulatory Accountability

The Medical and Dental Council of Nigeria's disciplinary process requires structural reform. The Tribunal currently lacks prosecutorial independence, public reporting obligations, and systematic data collection on outcomes.[93] A model drawing on the UK Medical Practitioners Tribunal Service and Professional Standards Authority for Health and Social Care, with independent panels, published decisions, and appellate oversight, would significantly enhance regulatory accountability. Mandatory clinical incident reporting, modelled on the UK's obligations under NHS standard contracts, would provide the data infrastructure necessary for systemic learning.[94]

7.0 Proposed Reforms for Nigeria

7.1 Dedicated Medical Negligence Tribunals

The most immediate reform required in Nigeria, is the establishment of a dedicated Medical Negligence Tribunal with jurisdiction over clinical negligence claims, drawing on specialised medical and legal assessors. Modelled on the Medical and Dental Practitioners Disciplinary Tribunal[95] and informed by the Indian consumer forum architecture,[96] such a Tribunal should operate at the federal and state levels, with simplified pleading rules, case management powers, and power to order interim disclosure of medical records. Filing fees should be means-tested, and a public defender-style service should be funded to assist self-represented claimants.

7.3 Compulsory Medical Indemnity and No-Fault Fund

Mandatory clinical indemnity insurance or participation in a centrally administered compensation pool should be required of all registered health professionals and healthcare establishments. A National Medical Injury Compensation Fund, modelled broadly on the New Zealand ACC treatment injury scheme[9798] but calibrated for Nigeria's public finance constraints, should provide a first-instance no-fault remedy for medical injury satisfying a defined clinical threshold. The fund could be financed by a combination of practitioner levies, healthcare facility contributions, and a dedicated appropriation from the Tertiary Health Care Fund established under the National Health Act 2014.[99] This reform would address both the access deficit and the practical problem of unenforceable judgments against insolvent defendants.

7.3 Amendment of the Legal Aid Act 2011

Section 7 of the Legal Aid Act 2011 should be amended to expressly include medical negligence claims, subject to a merits and means test, as eligible matters.[100] A specialist medical negligence legal aid fund should be established within the Legal Aid Council, staffed by practitioners with clinical negligence training. State Legal Aid Boards should be empowered to enter into arrangements with law school clinics, non-governmental organisations, and pro bono panels to extend representation capacity.

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[92]African Charter on Human and Peoples' Rights (Banjul Charter) (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, art 16.

[93]Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004, ss 15-16.

[94]NHS England, *Patient Safety Incident Response Framework* (2022); application of PSIRF principles is a mandatory contractual requirement under the NHS Standard Contract, with patient safety incidents recorded through the Learn from Patient Safety Events (LFPSE) service, which replaced the National Reporting and Learning System (NRLS) with effect from 30 June 2024.

[95]Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004, s 15.

[96]Consumer Protection Act 2019 (India), Part IV (ss 28–73), establishing the District, State, and National Consumer Disputes Redressal Commissions. See also *Indian Medical Association v V.P. Shantha & Ors* (1995) 6 SCC 651, applying the predecessor 1986 Act's consumer fora to medical services.

[97]Accident Compensation Act 2001 (NZ), ss 20–34 (treatment injury cover).

[98]Marie Bismark and Ron Paterson, 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety' (2006) 25(1) Health Affairs 278.

[99]Basic Health Care Provision Fund, established under the National Health Act 2014 (Nigeria), s 11.

[100]Legal Aid Act 2011 (Nigeria), s 8 and Second Schedule.

7.4 Codifying Informed Consent

The National Health Act 2014 should be amended, or secondary legislation promulgated thereunder, to codify the informed consent standard in line with the patient-centred approach established in *Montgomery*[101] and *Samira Kohli.*[102] A mandatory disclosure protocol should require healthcare providers to communicate, in plain language, the diagnosis, the nature and purpose of proposed treatment, material risks, and reasonable alternatives. Breaches of the protocol should give rise to civil liability and disciplinary consequences before the Medical and Dental Council of Nigeria.[103]

7.5 Mandatory Incident Reporting and Clinical Audit

The Medical and Dental Council of Nigeria, in collaboration with the Federal Ministry of Health, should introduce mandatory reporting of serious adverse clinical events to an independent National Patient Safety Agency, on the model of the Health Services Safety Investigations Body (HSSIB) in the United Kingdom, the successor body to the former Healthcare Safety Investigation Branch (HSIB).[104] Reported data should be published in anonymised aggregate form to support systemic learning. Public hospital accreditation under the standards developed by the National Health Insurance Authority should be made conditional on compliance with incident reporting and clinical audit obligations.[105]

7.6 Limitation Periods and Public Officers Protection Act

The application of the Public Officers Protection Act's three-month limitation period to medical negligence claims against employees of public hospitals should be definitively abrogated by statute.[106] A uniform three-year limitation period, running from the date of knowledge on the model of the UK Limitation Act 1980, section 14, should apply across all medical negligence claims, with a judicial discretion to extend in exceptional circumstances. This reform is essential to give victims adequate time to obtain records, commission expert opinion, and initiate proceedings.

8.0 Summary

The comparative analysis carried out in this article reveals that the gap between legal entitlement and practical remedy for victims of medical negligence is not inevitable: it reflects specific institutional choices, which can be differently made. The United Kingdom, despite its cost pressures[107][108], has developed a sophisticated framework of clinical dispute resolution, regulatory accountability, and patient safety investigation. The United States illustrates the costs, for patients and the system alike, of an adversarial model without coordinated no-fault supplementation.[109] New Zealand demonstrates that the abandonment of fault-based litigation in favour of universal no-fault compensation is administratively and financially achievable, and generates superior access outcomes.[110][111] India shows that consumer

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[101]*Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430.

[102]*Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1.

[103]See discussion at section 5.1 above (the patient-centred disclosure standard established in *Montgomery v Lanarkshire Health Board* [2015] UKSC 11 and *Samira Kohli v Dr Prabha Manchanda* (2008) 2 SCC 1) and the disciplinary framework under the Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004, ss 15–16.

[104]Health and Care Act 2022 (UK), establishing the Health Services Safety Investigations Body (HSSIB) with effect from 1 October 2023, succeeding the Healthcare Safety Investigation Branch (HSIB) (operational 2017–2023).

[105]National Health Insurance Authority Act 2022 (Nigeria), s 3.

[106]Public Officers Protection Act, Cap P41, Laws of the Federation of Nigeria 2004, s 2(a) (three-month limitation period for actions against persons acting in execution of a public duty or authority). See generally S.P.A. Ajibade & Co, 'A Review of Medical Negligence in the Nigerian Healthcare Sector: Utilising the Law as a Panacea' (Mondaq, 2023); on the courts' broad construction of "public officer" to include public bodies and institutions sued in their corporate names, see *Central Bank of Nigeria v Adedeji* (2004) 13 NWLR (Pt 890) 226.

[107]National Audit Office, *Costs of Clinical Negligence* (HC 1335, Session 2024–2026, 17 October 2025).

[108]Committee of Public Accounts, *Costs of Clinical Negligence*, Thirty-Seventh Report of Session 2024–2026 (HC 1335-equivalent select committee report, 2026).

[109]Michelle M. Mello, Amitabh Chandra, Atul A. Gawande, and David M. Studdert, 'National Costs of the Medical Liability System' (2010) 29(9) Health Affairs 1569.

[110]Accident Compensation Act 2001 (NZ), ss 20–34.

protection law can serve as a pragmatic vehicle for expanding access in a jurisdiction where dedicated clinical tribunals are absent.[112]

Nigeria, against this comparative backdrop, presents a case of compounded structural inadequacy: non-justiciable socioeconomic rights,[113][114] under-resourced legal aid,[115] an underdeveloped standard of care doctrine,[116] a regulatory framework with systemic enforcement gaps,[117] and procedural barriers that effectively foreclose judicial remedy for the majority of victims.[118] These inadequacies are not merely policy failures: they constitute a breach of Nigeria's obligations under the ICESCR,[119] the African Charter,[120] and the CRC, as well as the positive obligations inhering in sections 33 and 34 of the 1999 Constitution when read in light of the domesticated African Charter.

The reform agenda proposed in this article, which consists of a dedicated Medical Negligence Tribunal, a compulsory no-fault compensation fund, an expanded legal aid regime, codified informed consent obligations, mandatory incident reporting, and reformed limitation periods, might seem ambitious but it is achievable tractable. The legislative instruments are largely in place; what is required is political will, sustained civil society engagement, and a judicial culture that recognises access to justice for medical negligence victims as a constitutional and international legal imperative, not merely a private law aspiration. As the WHO's Global Patient Safety Action Plan 2021 to 2030 has recognised, patient safety is a global health priority: effective legal remedies are an indispensable component of that commitment.[121]

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[111]Marie Bismark and Ron Paterson, 'No-Fault Compensation in New Zealand: Harmonizing Injury Compensation, Provider Accountability, and Patient Safety' (2006) 25(1) Health Affairs 278.

[112]Consumer Protection Act 2019 (India), Part IV; see also *Indian Medical Association v V.P. Shantha & Ors* (1995) 6 SCC 651.

[113]Constitution of the Federal Republic of Nigeria 1999, s 6(6)(c) (ousting judicial jurisdiction over Chapter II).

[114]Constitution of the Federal Republic of Nigeria 1999, Chapter II (ss 13–24), especially s 17(3)(d) (directing state policy toward "adequate medical and health facilities for all persons").

[115]Legal Aid Act 2011 (Nigeria), s 8 and Second Schedule (cross-reference to the earlier discussion in this dissertation of the Act's narrow enumerated categories and discretionary "interest of justice" standard).

[116]*Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, 587 (McNair J).

[117]Medical and Dental Practitioners Act, Cap M8, LFN 2004, ss 15–16.

[118]Public Officers Protection Act, Cap P41, LFN 2004, s 2(a); the Legal Aid Act 2011, s 8 and Second Schedule.

[119]International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 993 UNTS 3, art 12.

[120]African Charter on Human and Peoples' Rights (Banjul Charter) (adopted 27 June 1981, entered into force 21 October 1986) 1520 UNTS 217, art 16; domesticated in Nigeria by the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9, LFN 2004.

[121]WHO, *Global Patient Safety Action Plan 2021-2030* (World Health Organization 2021) 7.