THOUGHT LEADERSHIP

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Healthcare Disputes In Nigeria: Navigating Liability,Insurance, and Compensation Claims.

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Introduction

Healthcare disputes in Nigeria sit at the intersection of law, medicine and public policy. They span a wide spectrum, including clinical negligence claims, professional discipline proceedings, regulatory enforcement and mass-tort style claims arising from systemic failures within healthcare delivery .

This article examines the legal landscape that governs liability, insurance and compensation in healthcare disputes; diagnoses the practical and structural problems that frustrate fair and timely outcomes; and proposes pragmatic, forward-looking measures aimed at reducing harm, improving dispute resolution and safeguarding the interests of patients, healthcare practitioners and payors.

The Legal Landscape: Who, What and How

At its core, a healthcare dispute is a legal claim arising from an alleged breach of a legal duty owed by a healthcare provider (individual or institution) to a patient. Those claims typically proceed along three tracks:

- **Professional/Regulatory Discipline** — This refers to complaints lodged with licensing and professional bodies that may lead to sanctions, suspension or deregistration. Professional codes of conductand regulatory statutes enforced through the disciplinary machinery of the medical and allied councils are the primary route for addressing conduct that raises issues of professional misconduct.

- **Civil Liability/Compensation** — Claims brought before civil courts seeking damages for negligence in tort, breach of contract (where there is an express or implied contractual relationship), or, less commonly, statutory causes of action. Such claims typically seek monetary compensation for physical injury, emotional harm, economic loss, or wrongful death.

- **Criminal Liability** — This is applicable only in exceptional circumstances where conduct rises to the level of reckless or intentionally harmful acts. In such cases, criminal prosecution may follow. Examples includes unlawful killing or grievous bodily harm.

The statutory and regulatory architecture governing these disputes includes the National Health Act and various professional regulatory frameworks. Licensing authorities set standards of practice, enforce disciplinary measures and issu professional guidelines which courts frequently rely upon when determining the standard of care.

Liability: Standards and Practical Proof

- **Standard of Care** -Negligence claims in healthcare are assessed against an objective standard: the level of care reasonably expected of a competent practitioner acting in similar circumstances. Expert medical evidence is essential. Courts will evaluate whether the provider adhered to accepted clinical protocols, obtained appropriate consent, and acted with the skill, prudence and foresight a reasonably careful practitioner would exercise.

- **Vicarious Liability and Institutional Responsibility.**-Hospitals and clinics may be held vicariously liable for the acts and omissions of their employees. . Beyond this, institutions have independent dutiesto maintain systems including effective sterilisation procedures, record keeping, supervision and to ensure informed consent processes. Failures at systemic level such as poor protocols or inadequate staffing) can ground liability even where individual clinicians acted competently.

- **Consent and Shared Decision**-Making. Valid informed consent is both an ethical and legal requirement. Failure to obtain or to disclose material risks can found a claim even where the clinical care was otherwise competent. The modern trend is towards patient-centred disclosure with materiality assessed by reference to what a reasonable patient would want to know

Insurance: Current Reality and Gaps

- **Professional Indemnity Insurance** - Professional Indemnity Insurance (PII) is central to managing financial risk. In practice, coverage in Nigeria is uneven: while large tertiary hospitals and established private clinics typically maintain PII, many smaller facilities and individual practitioners operate with inadequate or no cover. Thisgap creates dual risks: first, legitimate claimants may be unable to recover full compensation; second, uninsured providers face catastrophic personal exposure.

- Institutional Cover and Third-Party Costs - Healthcare institutions must consider not only professional liability but also property, product liability (for medical devices or pharmaceuticals), and employer's liability. Insurers increasingly exclude certain pandemic-related or systemic exclusions, a risk that needs contractual and underwriting attention.

Areas for Improvement.
The sector would benefit from regulatory encouragement or mandatory minimum PII levels pooled risk schemes for smaller providers, and clearer claims notification practices. Insurers and health facilities must also improve claims handling timelines and specialist medico-legal expertise to assess claims accurately and promptly.

Compensation Claims: Procedural and Substantive Challenges

- **Access to Justice and Evidential Burdens** - Medical negligence litigation is resource-intensive requiring expert witnesses, medical records, and sometimes lengthy litigation. Poor record-keeping, weak retention practices and incomplete consent documentation frequently undermine claimants and defendants alike.

- **Quantification of Damages** - Courts award compensatory damages for pain, suffering, loss of amenity, and economic loss. Assessing future care needs and loss of earnings require multidisciplinary input. In the absence of standardised tariffs, awards depend heavily on judicial discretion and evidence.

- **Alternative Dispute Resolution (ADR)**- ADR Mechanisms: mediation, negotiated settlements, structured early offers remain under-utilised. Where effectively deployed, ADR can deliver faster, more private and rehabilitation-oriented outcomes, reduce legal costs and preserve professional relationships.

Systemic Obstacles to Fair outcomes

- **Fragmented Record-Keeping.**-Absence of interoperable health records and inconsistent retention policies make proof difficult.
- **Capacity gaps in Forensic and Medico**-Legal Expertise -Courts and insurers rely heavily on expert testimony; limited pools of impartial experts delay resolution.
- **Insurance Shortfalls**- Underinsurance or uninsured providers mean claims either fail on enforceability or bankrupt small providers.
- **Regulatory Fragmentation** - Multiple regulators and inconsistent enforcement weaken deterrence and clarity.
- **Public Distrust and Reputational Risk.** -High-profile adverse events inflame public sentiment and complicate settlement dynamics.

Takeaway

Mandatory minimum professional indemnity for facilities above defined thresholds, paired with a subsidised pool for small clinics. This protects patients and stabilises the market.

- Specialist Clinical Negligence Pathway, including a fast-track preliminary assessment panel composed of independent clinicians and mediators to triage claims, mandate early disclosure of records, and recommend ADR where feasible.

- Standardised Medical Records and Retention Protocol — preferably digital to improve evidence availability and clinical governance.

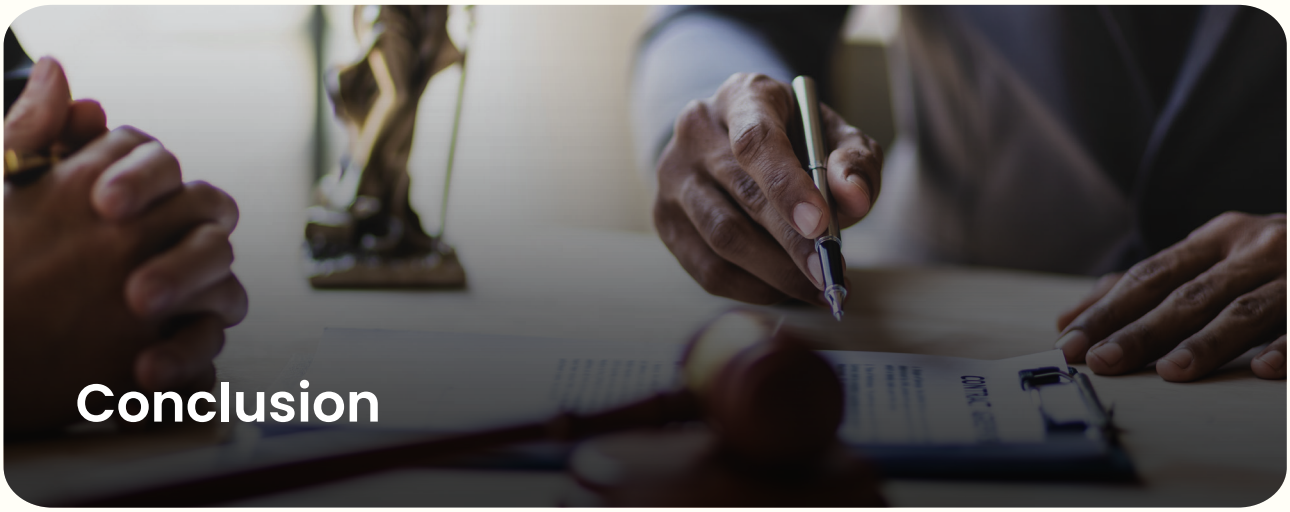
- Compulsory Pre-Action Protocol — requiring early exchange of records, expert reports and a f negotiation window prior to litigation. This will reduce frivolous litigation and encourage settlement.

- Stronger Regulatory Discipline and Coordination enhance the capacity of professional councils to investigate and sanction misconduct and create protocols for parallel regulatory and civil processes.

- Investment in Medico-Legal Expertise including public-private partnerships to train independent expert witnesses and to create an accredited roster for court and mediation use.

- Promotion of ADR and Rehabilitation-Focused Remedies shift emphasis from purely monetary compensation to patient rehabilitation, apologies, and systemic remediation where appropriate.

- Data and Transparency Initiatives such an anonymised national register of adverse incidents and outcomes (anonymised) to allow pattern detection and system reform.



Conclusion

Healthcare disputes will never disappear as they are an inevitable consequence of complex systems delivering inherently risky services. The policy challenge is not how to eliminate disputes but how to manage them in ways that prioritises patient safety, ensure fair compensation where harm occurs, and sustain a resilient health sector.

For Nigeria, the path forward is both practical and achievable: enforce proportionate insurance requirements, standardise records, triage claims through specialist panels, incentivise ADR, and bolster regulatory capacity.

These steps where they are properly implemented will reduce adversarial litigation, improve patient outcomes, and restore public confidence, transforming disputes from adversarial endpoints into catalysts for learning and system improvement.

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