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Medical Negligence in Nigeria and the Obstacles to Litigation

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Abstract
Within the medical spectrum, negligence is a breach of duty of care to his/her patient. Negligence occurs in any and every healthcare facility by medical practitioners, including surgeons, doctors, nurses, pharmacists and laboratory attendants. The occurrence of medical negligence is largely attributable to institutional deficiencies and character flaws, and therefore a matter of concern in many countries. The occurrence of medical negligence exposes patients to injuries, delay hospitalization and in some cases leading to death. Instituting legal action against injuries sustained while receiving medical care may be considered as avenue to seek redress by victims of medical negligence. However, seeking legal redress is a herculean task for most of the victims, especially in developing countries. Given the dearth of publications on the extent of medical litigation, this article is aimed at filling the existing gaps in knowledge on the subject matter. Using secondary source, the article established that various factors constitute obstacles to litigation in the occurrence medical negligence in Nigeria. These include poor awareness, cost of litigation, religious fatality, complexity/corruption associated with judiciary and difficulties in obtaining expert witnesses, among others. In its conclusive part, the paper flags the need for efforts towards promoting quality healthcare, coupled with adherence to protocols by healthcare givers. These are in addition to enthronement of justice, such that victims and perpetrators of medical negligence are appropriately served. When these, among other strategies are in place, the occurrence of medical negligence and its attendant litigation would be mitigated.

Keywords: Negligence, Practitioners, Victims, Litigation, Mitigate

Introduction
Globally, medical profession is considered as indispensable, as its activities touch on the lives of members of the society. Therefore, healthcare givers are trained and expected to render medical services in accordance with rules and protocols of medical science. As a corollary to the academic and professional trainings of health workers at national levels, physicians who have earned their degrees and qualifications in other jurisdictions need to adhere to the pertinent regulations for practicing in another jurisdiction, such as licensing or certification, before they can practice medicine therein (Medical & Dental Practitioners Act, 2004; Violato, 2013). However, some healthcare providers do not act in line with rules and protocols, and therefore creating room for negligent acts. Medical negligence occurs when health practitioners or health institutions fail to perform the expected duties of their respective jobs. Yohanes (2022) conceived negligence as reckless behavior where the actions taken by medical practitioners or health facilities are below the standard of medical services. According to Chukwuneke (2015), medical negligence

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constitutes an act or omission by a medical practitioner, which falls below the accepted standard of care and therefore resulting to injury or death of a patient. In this article, medical negligence is considered as physician's failure to take appropriate actions while given treatment to patients and therefore liable to prescribed sanctions. Medical negligence also involves failure of healthcare providers to act in accordance with established professional protocols and therefore exposing patients to injuries, disability or death. Examples of such medical negligence would be a practitioner engages in misdiagnosis, improper transfusion, wrong site surgeries, and wrong administration of drugs and provision of inappropriate treatment, among others.

The occurrence of medical negligence varies among healthcare providers and facilities, and depends on the quality of the professionals, coupled with adherence to the existing rules and protocols. Thus, when a patient receives treatment in a health facility that is understaffed, ill equipped, or otherwise medically compromised, chances are higher that such patient will suffer medical negligence (Adegboyega, 2017). In the case of Nigeria, the healthcare systems have suffered dearth in terms of availability of man power and infrastructure. Highlighting the global challenge of medical negligence, Donald (2014) stressed that 80 percent of the incidents involved death or serious injury to unsuspecting patients, bringing preventable, needless and untold grief to families; literally leaving patients worse than they were before they sought medical attention.

In addition, medical litigation is a process whereby a client files a lawsuit against a physician over perceived wrong treatment. In the event of medical negligence, court is one of the channels for seeking redress. Countries have different standard and regulations in medical practice with the formation of several regulatory bodies such as the Nigerian Medical and Dental Council (NMDC) in Nigeria and Health Professions Council of South Africa for the promotion of quality health care delivery, at the same time monitoring the activities of the practitioners. In Nigeria, patient who is suspicious of negligence has a right to petition the Nigerian Medical and Dental Council and to report a case of negligence. While illustrating the goals behind malpractice litigation, Keeton, et al. (1984) stated that they include the need to deter unsafe practices, to compensate persons injured through negligence and to exact corrective justice. Oyebode (2013) also submitted that clients' institute malpractice claim due to poor relationship with the health care provider before the alleged error.

As earlier indicated that the occurrence of medical negligence is a global health problem, however, and contrary to what is obtainable in most of the developed countries, where aggrieved clients institute legal actions against erring health workers and institutions, the same could not be said of Nigeria. For instance, Birks (2018) reported that not less than 208,415 medical negligent complaints are received annually in the United Kingdom. Similarly, Courts Service Annual Report (2019) indicates that medical negligence disputes continue to be resolved by means of litigation in Ireland. Studies have established that the rate, at which medical negligence claims are reported in Nigeria, and Africa as a whole, is relatively low. For instance, Oyebode (2006) reported that between 1996 and 1997, the sums of two hundred and thirty-five million pounds (£235) were awarded to victims of medical negligence in Britain, resulting from litigation. In addition, Diyer (1999) reported that negligence claims against medical practitioners rose 13-fold between 1989 and 1998 in Britain. In the case of Nigeria, Adegboyega (2017) established that many clients have suffered medical negligence due to lack of facilities, inexperienced medical staff and poor

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management, yet few cases of medical negligence are reported. It is worthy of note therefore to state that many cases of medical negligence in developing countries (Nigeria inclusive) never make it to court; instead, they are settled informally. Against this background, the article is aimed at examining the burdens associated with instituting litigation and seeking redress at the aftermath of medical negligence in Nigeria. The article is divided into six sections: methodological approach, episodes of medical negligence in various health facilities across the globe, global climate of medical negligence litigation, problems associated with instituting litigation against medical negligence. The last section is the conclusion.

Methodological Approach

The article adopts integrative approach of literature review. Through this approach, available publications (articles, conference papers and textbooks, among others) focusing on medical negligence in different health facilities were accessed and reviewed. The articles were sought from Medline, PubMed Science, Google Scholar and other online resources. While searching for articles, proper attention was given to diversity, such that the challenges associated with medical negligence litigation in many countries are better explained. This was done to provide readers with better ideas of the subject matter.

Episodes of Medical Negligence in Various Health Facilities across the Globe

Violato (2013) opines that in contemporary medical practice, wholesome patient safety has not been satisfactorily achieved with thousands, and possibly, millions of patients sustain injuries or dying from medical errors across the world. Historically, Chapman (1982) reported that the earliest case of medical negligence was the English case of Stratton v Swanlond that was decided in 1374 where a surgeon tried to repair a woman's mangled hand. The woman claimed the surgeon said he could cure her, but after the procedure she was still deformed. The case was dismissed on a procedural error, but the judge set ground rules for contemporary medical negligence cases, stating that physicians could be held liable when they are negligent, but if properly treated, they would not be liable just because it did not cure the patient.

The Global Burden of Disease Study (2015) attributed death of 142,000 people worldwide in 2014 to medical negligence. With specific focus on the United States of America, James (2013) estimated that between 210,000 and 400,000 deaths attributable to medical negligence were recorded within few years prior to the study. A study by Burroughs, et al. (2005) established the occurrence of various types of medical errors in health facilities in the United States of America. The errors included diagnosis (22%), mistakes by nurses (12%), errors of test/procedure (10%), and errors attributable to medical equipment (9%), being mistaken for another patient (8%), and injury due to falling (6%). Similarly, Jena, et al. (2011) reported that up to 7.4% of healthcare staff are accused of negligence each year. Singh et al. (2017) estimated that 1 in 20 adult patients in the United States experience diagnostic errors, which accounted for over a quarter of claims and for 35% of malpractice payments.

Similarly, a study conducted by Vincent, et al. (2001) show significant number of patients who received treatment in the hospitals in 1999 suffered medical negligence in the United Kingdom. In addition, Bourn, et al. (2016) reported that malpractice issues involving general

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practitioners have increased more than two-fold in the United Kingdom between 2007 and 2012. Davis, et al. (2007) also found that 11.2% of patients on admissions in New Zealand hospitals experienced medical errors while receiving treatment in 1998. Health consumers in Canada also experienced medical negligence as revealed by a study conducted by O' Hagan, et al. (2009). The reported medical incidents included wrong medication, wrong prescription, errors of filing, and surgical errors.

A study by Ponte, et al. (2013) established that cases of medical negligent constitute the fourth cause of mortality in developing countries. Connectedly, a study conducted by Khoo, et al. (2012) documented incidence of medical negligence among patients in different health facilities in Malaysia between 2008 and 2011. The identified cases included errors of documentation (18.0%); medication errors (21.1%); investigation errors (21.7%); errors of administration (14.5%), and diagnostic errors (3.6%). The authors also established that most of the errors were considered as having a potential for causing serious harm to the victims. Datta (2014) reported similar scenario in India where about 5.2 million cases of medical errors were recorded within ten years prior to the study. In the case of Thai, Armbretch (2016) established that for a period of fifteen years prior to the study, over 3,000 complaints were filed against medical practitioners and institutions, with over 75 health workers in public health facilities have had malpractice suits brought against them. Relying on documentary source, Malherbe (2013) reported that between April 2011 and March 2012 up to 2,403 malpractice complaints were received in South Africa. In South Africa, Kama (2017) reported the case of a 1-year-old baby who died on his grandmother's back after they were turned away from three different healthcare facilities in one of the townships in Cape Town. The author also reported another incident in the same township, where a teenager gave birth on the pavement outside the gates of a health facility because she was not allowed access (Kama, 2017).

In the case of Nigeria, Imam & Olorunfemi (2004) submitted that cases of stroke misdiagnosis are recorded in Nigerian hospitals on regular basis, partly attributable to lack of radiological tests, including computerized tomography scans. Abioye and Adeyinka (2002) also discovered that 75 cases of medical negligence were reported in various health facilities in Osun State, Nigeria between 1999 and 2001. The identified errors included medication errors, surgical errors, injection errors, mostly attributed to child immunization and errors of referral. Similarly, a hospital study-based conducted by Akinloye (2007) established that 15% of the patients on admissions in a public health facility in Osun State between 2004 and 2006 were attributable to medical negligence. The author attributed the incidence of most of the medical negligence to the infiltration of quacks into the medical profession. Ohajuru, et al. (2011) reported an incidence of 21% surgical site infections (SSI) at Obafemi Awolowo University Teaching Hospital, Ile Ife, Nigeria.

With reference to health facilities in Edo State, Obarisiagbon (2019) averred that medical negligence constitutes major health hazard in Nigeria. Ogundare (2019) also reported that not less than 33.3% of Nigerian patients were exposed to medical incidents beyond what took to health facilities. Similarly, Odunsi (2023) reported an incident where a woman who underwent prolonged labour (twenty-two hours) in a private health facility in Iya-Iba area of Lagos State, Nigeria. The woman eventually delivered a baby girl but unable to make any sound for three days. On the fourth

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day, the new born baby was reported to have a seizure. Upon referral, a brain scan at Yaba Psychiatry showed that the baby suffered from primary generalized epilepsy attributable to carelessness (alleged) on the part of health workers at a private health facility.

Inference from the existing studies is that there is no healthcare facility immune to medical negligence. The scenario further raises question about safety of patients in various health facilities.

Global Climate of Medical Negligence Litigation

Alluding to the complex nature of healthcare provision, Chiangi (2019) reiterated that the process of attending to patients requires the application of different therapeutic processes ranging from diagnosis to prescription, injection, surgical operations and drug administration, among others. While carrying out the processes by medical practitioners, errors could occur and thereby making patients to suffer injuries or fatalities. In such circumstance, Chiangi (2019) expressed that the notion of whether or not the medical practitioner is culpable arises for determination. Thus, Studdert, et al. (2004:283) opined that social goals of negligent litigation are three: to deter unsafe practices, to compensate persons injured through negligence of medical practitioners, and to enable corrective justice. Over time, measures, in form of regulatory ethical codes for medical practice, began to emerge in safeguarding the interest of patients. Prominent in this respect was the historical Hippocratic Oath, as contemporarily provide (Mason, et al. 2002). The Hippocratic Oath, as a global code of medical practice, prescribed generally that healthcare providers must act for the good of their clients. Thus, when such legislations, measures and ethics are breached, the erring practitioners and institutions are not immune from litigation. The effectiveness of these measures in mitigating the occurrence of medical negligent remains debatable. Thus, the fundamental objectives behind litigation against medical negligence are to safeguard the standards of the medical profession and to protect the public against unskilled vendors of medicine who would be as injurious to the clients and community at large.

Odunsi (2023) posited that with the inherent imperfection of human, the issues of medical negligence and other factors become components of human existence, with attendant need to adopt legal redress. The author expressed that the urge to instigate litigation against medical malspractice began to develop in the nineteenth century. Williams (2009) posited that the development of negligence litigation was attributable to 'scientization' of medicine, coupled with the improvements in science and technology that created new standards and expectations of perfection from medical practitioners. Faden and Beauchamp (1986) also posited that in the case of Europe medical litigation began in the late 1950s to early 1970s, when lawyers broke the traditional 'conspiracy of silence', which hitherto discouraged physicians from testifying about the negligence committed by colleagues or serving as expert witnesses. Thereafter, health care institutions in Europe developed interest in monitoring the quality and controlling the expense of medical treatment. DeVille (1990) opined that the culture of medical litigation began to appear in the United States in 1800. This development provides a platform for medical boards to sanction physicians who compromised the standard and quality of care to clients. In the Germanic empire, Pienaar (2016) reported that medical negligence was governed by legislation that provided for a medical practitioner who committed negligent acts against patients to face legal redress in the

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hands of victims and their relatives. Where the patients survived but suffered injury, it is recommended that the medical practitioner had to pay a fine to the family.

Examining the trends of health-related litigations, Chin (2013) documented that China recorded an increase in the number of litigations against medical practitioners from 29 to 56 cases in 2006 and 2011 respectively. In the case of Malaysia, Kassim & Najid (2013) reported that 113 negligence cases involving health workers in public health institutions were reported between 2005 and 2009. A study conducted by Mello & Brennan (2001) also revealed that Taiwan is among the countries where medical negligence is criminalized and as such, at least one Taiwan physician is found guilty every three months of negligent cases. In a related development, Smetzer (2010) reported a case where a nurse in Wisconsin (United States of America) committed drug administration error against a 16-year-old patient, resulted in the patient's death. The case was reported to a Medical Tribunal, which confirmed that the nurse was guilty of malpractice. Thereafter, the erring nurse was subjected to the prescribed punishment guiding medical practice in the country.

Similarly, Ayudhaya (2017) reported that a doctor was sentenced to three years in prison at Tungsong Provincial Court in Thailand over the death of an elderly patient in 2002. The erring doctor was reported to have wrongly administered a spinal anesthetic to the patient admitted for appendicitis. The negligence made the patient to develop cardiac arrest and her subsequent death. AlJarallah and AlRowaiss (2013) also established that it is a common practice for victims of medical negligence in Saudi Arabia to institute legal actions against healthcare providers and institutions whenever they perceive to untoward results associated with healthcare delivery. With specific reference to Lebanon, a study conducted by Al-Salim (2014) revealed that more than a thousand complaints related to medical negligence were instituted either by aggrieved patients or by their relatives against suspected health workers between 1996 and 2013. Out of the received complaints, it was reported that 400 complaints were referred to the disciplinary council, with 300 disciplinary rulings and penalties were issued in accordance with the law. From the 300 issued rulings, it was established that 50 resulted in physicians being suspended from work for a period ranging between two and six months; while a physician was permanently banned from practicing medicine.

With reference to South Africa, Pepper & Slabbert (2011) reported that South Africa is becoming prominent in matters relating to medical negligence litigation, resulting in medical insurance premiums rising rapidly and doctors are now more wary of being sued by patients than in the previous years. Malherbe (2013:83) also reported increased in medical litigation claims, which were more than doubled between 2011 and 2012. Thus, Bateman (2011) expressed that the most expensive medical negligence claim (as at the period) to be paid on behalf of a South African doctor was R17 million, which was paid to a patient who suffered catastrophic neurological damage in 2010. The Medical Law website (2015) also reported that the percentage of reported negligence claims in South Africa rose by over 130 % over a period of two years. This development was attributed to the advancement of awareness of patient rights globally.

In the case of Nigeria, efforts at minimizing medical negligent dated back to the colonial era when the colonial government devoted attention aimed at ensuring that the quality of health services obtainable to the British administrators and few privileged Nigerians, working with the

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government. At the post-independence era, Yusuf (2010) reported that the Nigerian government enacted Medical Act known as Act No.9 of 1963, aimed at protecting, promoting and maintaining the health safety of the public by ensuring that the health practitioners sustain professional standards. According to the Code of Medical Ethics in Nigeria (2008), the Act Cap 221 Laws of the Nigeria in 1990, which set up Medical and Dental Council of Nigeria (MDCN) replaced the Act No.9 of 1963.

As a regulatory body, the Nigerian Medical and Dental Tribunal and other health professional bodies respond to incident of medical negligence by conducting trials in order to establish the gravity and magnitude of negligence coupled with the necessary sanctions against the erring practitioners. For instance, Babalola (2013) reported a case of medical practitioner in Nigeria who was found guilty of negligent, failure to secure the professional services of an anesthetist and of qualified registered nurses to provide as required before, during and after the caesarian operation of a patient and eventually led to her death. Thereafter, the negligent action was reported to the Nigerian Medical and Dental Tribunal. After due consideration and conviction, the Tribunal suspended the erring doctor from practices for six months.

The implication of the findings is that medical negligence is not welcome in the eyes of the law and therefore the concerned aggrieved victims and their relatives considered legal actions as the best options to seek redress. While appreciating the various disciplinary actions meted against erring health providers, it is worthy of note that majority of the victims of medical errors in Nigeria, especially the less privileged found it difficult to seek legal redress against erring personnel or health institutions. This is attributable to many factors, which are discussed in the following section.

Obstacles Associated with Instituting Litigation against Medical Negligence

While it is expected that aggrieved clients should institute legal actions against the occurrence of medical negligence, doing so in some cases are considered as herculean task for victims and their relatives. This is in spite of the fact that the probability of being compensated is high, provided that clients through their lawyers are able to present and proof their claims beyond any reasonable doubt. Narratives from the preceding section(s) established that medical negligence occurs in various health facilities globally, this article submits that few incidents are likely to be resolved in court. With particular reference to Nigeria, Olofinlua (2015) expressed that many patients either die or sustain injuries in Nigerian hospitals as a result of medical negligence, yet most incidents go unreported. Obafemi (2017) acknowledges that over the years Nigeria has developed an appreciable jurisprudence on medical negligence, through the courts. In addition, the standard of care is set by the Medical and Dental Council of Nigeria. Other medical bodies including the Nigerian Medical Association, the Medical and Dental Consultants Association of Nigeria also have principles of ethics guiding their members with disciplinary measures in place to ensure compliance (Chukwuneke, 2015).

Notwithstanding, Odunsi (2019) expressed that volume of medical negligence litigations in Nigeria is relatively low when compared with developed countries such as the United States of America and Britain. Among the obstacles faced by clients in making claims for medical negligence is obtaining relevant medical records to support litigation. Once a client noticed that

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negligent action has occurred, he is likely to seek clarifications in order to determine the next line of actions, including litigation. It is also important for the client to find competent legal experts, who are willing to pursue the case. Doing so also requires adequate evidence on medical negligence but which are often not circulated to the public. Patients are routinely denied access to have basic information about their diagnoses and treatments. This is one of the strategies developed by healthcare institutions as a cover up against litigations in the occurrence of medical negligence. Similarly, the desire to seek redress by patients in the event of medical negligence is hampered by difficulty in obtaining expert medical witness opinions, including evidence based medical records. This is important as medical negligence matters have always been a challenge for lawyers due to the intricate aspects of the proficiency only known to the medical practitioners and experts. Similarly, for negligence to be established against physician, a plaintiff must demonstrate that a duty of care exists; there was a breach of that duty; and that the damage suffered is caused by that breach. Thus, courts have to rely on medical experts in order for the courts to come to a reasonable and non-controversial decision. Kassim (2008) expressed that medical expert(s) must be willing to provide voluntary oral evidence and be cross-examined to enhance litigation process; otherwise, the complainant would find it difficult to establish proof against a perceived erring medical practitioner. However, experts opinions are always difficult to secure in the event of medical negligence as lawyers do advice their clients (medical practitioners) to maintain silence and not to discuss the case details with anyone (Seubert, 2007). The unwillingness of expert witnesses to provide evidence against their colleague and non-accessibility to medical records in the pre-action stage is often serious obstacles in initiating claims against physicians in court. Considering the difficulties associated with obtaining experts advice in the event of instituting legal redress against the occurrence of medical negligence, Kassim (2008) employs the term ‘lottery’ to describe the unpredictable outcome of malpractice litigation.

Similarly, Yohanes (2022) opined that medical procedures are organized in a corporate organization, known as hospital. Thus, as a corporation, health services have shifted their orientation from charity to the industrialization of medical services with capital support for medical equipment, human resources and finance. The responsibility of service provider is not carried out by a doctor but is taken over by hospital as a legal entity. With this development, Yohanes (2022) expresses that establishing liability for medical negligence becomes more complex and must be seen patient's relationship with a legal entity (hospital) that is always interested to protect its image and perceived integrity.

Olofinlua (2015) also admitted that incidents of medical negligence contribute to death of patients in Nigerian health facilities. However, the author decried that comparatively low numbers are litigated in the courts for redress due to some factors. The challenges associated with seeking redress in the occurrence of medical negligence are enormous, and therefore rarely happen in Nigeria. Justifying this position, David (2014) explained that most Nigerian citizens have poor knowledge of their constitutional rights, and usually finding it difficult to understand when their rights (including rights to quality and responsive health) are violated.

Similarly, Bello (2000) established that there were cases of poor diagnosis of patients in the various health facilities in the Northern Nigeria, leading to death and aggravation of illnesses, but the victims hardly realize them and even when they are aware, they do not institute legal actions

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against the suspected healthcare providers/institutions. The study associated poverty, religious fatalism and poor awareness among people as partly responsible for culture of silence towards litigation in the region. Thus, Osaghae (2019) submitted that in a country such as Nigeria where most of the citizens have been pauperized by bad governance and inhuman economic policies, the ordinary citizen would find it very difficult to spend his or her meager income to litigate against perceived occurrence of medical negligence in his/her care.

Ahmed-Kazeem (2016) also expressed that most Nigerians have a vague knowledge of the existence or enforceability of the laws governing medical negligence and therefore making it difficult for them to institute litigation in the event of medical negligence. Similar concern was expressed by Obafemi (2017) who posited that victims of medical negligence in Nigeria are not likely to succeed in a claim for negligence under conventional tort law principles, for several reasons: the difficulty of adducing expert evidence; the application of a conservative test for determining professional negligence, and difficulties in regard to proof and causation. The complexity associated with the determination of culpability in the occurrence of medical negligence is reiterated by Tumelty (2023) who submitted that establishing the occurrence of medical negligence, a plaintiff must demonstrate that a duty of care existed, there is a breach of that duty, and that the damage suffered is caused by that breach. In addition, Odunsi (2009) noted that most Nigerians have low confidence in the country's justice system, coupled with long trial periods and prevailing culture of corruption.

A study conducted by Adegboyega (2017) also revealed that in spite of the occurrence of medical negligent in clients' healthcare in Osun State, Nigeria, none of the victims complains either to legal authorities or to the regulatory bodies in the country. Factors responsible for inaction among the victims include ignorance of health litigations, fatalism and the challenge of poverty faced by most of victims. In addition, victims avoided courts in order to maintain a cordial relationship among families on matters that relate to life and death. Findings from the study also indicate that some of the victims and their relatives considered the occurrence of medical errors as acts of God, and therefore resigned themselves to fate. The propensity to litigate by the victims is also hampered by lack of awareness of their legal and human rights as well as rules of law.

In a similar development, a study by Oyetunde (2011) revealed that Nigeria has a greater percentage of unreported malpractice incidents, especially among the less privileged. He pointed out that the less privileged may not have the means to seek legal redress against the hospital or medical practitioner that facilitates the occurrence of medical negligence. In an environment where ignorance and poverty are rampant, people's fundamental rights are often violated. In addition, the legal Aid system in Nigeria is not very effective and not everybody may be eligible for Legal Aid. Obafemi (2017) also stressed that litigants in the area of human rights and constitutional law face a hurdle, such that it becomes formidably difficult for them to win claims and, even when successful, yield either no compensation or very low amounts of compensation. Considering the issues surrounding the Nigerian legal system, it was difficult for most victims of medical negligence to initiate legal actions against erring health workers. Nigerian law has other gaps, which can be used against Nigerian patients. According to Olufinlua (2015), where the law requires a plaintiff to give pre-action notice to the defendant, failure to do so renders the suit

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incompetent and therefore the case will be dismissed. As a result, most victims of medical negligence in the country have suffered the consequences of medical negligence in silence.
Additionally, doubts over the outcomes of medical litigation can serve an inhibiting factor aggrieved clients or their relatives from embarking on litigation in the event of medical negligent in Nigeria. Alluding to this point, Olufinlua (2015: part 2) submitted thus: Another thing that happens is that with the ticking of the clock, self-defeating thoughts often creep into many Nigerian hearts, … "They will ask: 'Will I even succeed? How long will it take? If I go there now, maybe the people will get the judge compromised or they will hire a lawyer better than mine. Or I will go there and seek one million naira after spending 500,000 naira, and the judge may award 30, 000 naira.

Conclusion

This article examines obstacles associated with instituting legal redress against negligent acts committed by medical practitioners while rendering services to their clients. The article established that medical negligence constitutes public health challenge in most countries of the world. When medical negligence occurs, the consequences suffer by victims may include disability, paralysis or death. When victims litigate against medical negligence, it provides opportunity to seek redress through the legal system. Against expectation, most victims are faced with obstacles while initiating litigation. These include the difficulty of adducing expert evidence and those relating to proof and causation and complexity/corruption associated with the judiciary, among others. The implication of the identified challenges is that many cases of medical negligent are not reported and therefore the involved medical personnel may not be brought to book. Thus, health litigation is considered to be fluid, cumbersome and complex.

From foregoing, this article advocates that the Nigerian health care system must promote quality of care, coupled with culture of open communication between clinicians and patients, which should persist even after a patient has experienced a negative outcome (regardless of who or what is to blame), allows for robust process improvement, and offers compensation to injured parties. Thus, transparency and open communication with patients and families about medical errors allow medical practitioners to fulfill their ethical obligations to their patients even when outcomes are against expectation. While advocating for quality of care, this article concludes that creating a cultural, legal, and economic environment where communication and resolution programs can thrive may be an effective approach to creating a win-win situation for patients, physicians, and therefore society as a whole. At the same time, justice must be done to the victims of medical negligence and a punitive deterrence must be adopted in deserving cases.

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