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SYNTEGRAL LEGAL PRACTICE

SILENCE IN HEALTHCARE: NON-DISCLOSURE OF MEDICAL ERRORS AND THE PROTECTION OF PATIENT RIGHTS

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INTRODUCTION

Medical practice, at its core, exists to preserve life and alleviate suffering. Yet it is carried out by human actors operating within imperfect systems. The inevitability of error captured in the maxim errare humanum est is not, in itself, the central concern. Rather, the legal and ethical fault line emerges in what follows: the failure to disclose those errors.

In Nigeria, the issue of transparency in healthcare has moved from the periphery to the center of legal and policy discourse, particularly within the context of ongoing reforms between 2023 and 2026. At stake is a fundamental question: whether the healthcare system will prioritise institutional self-preservation or the rights and dignity of the patient.

A PRACTICAL ILLUSTRATION

Consider a relatively common scenario. A patient undergoes what is described as a routine surgical procedure. Post-operatively, complications arise persistent pain, delayed recovery, and unexpected deterioration. The treating team attributes these developmentts to “normal post-surgical complications” and reassures the patient accordingly.

Months later, following further investigation at a different facility, it is discovered that a surgical instrument or material had been inadvertently retained during the initial procedure. The patient is now faced not only with additional medical intervention, but also with prolonged suffering that might have been mitigated had the error been disclosed promptly.

In such circumstances, the harm is twofold. First, there is the primary clinical error. Secondly and often more significantly there is the failure of candour. The patient is denied the opportunity to make informed decisions, seek timely corrective care, or pursue appropriate remedies. What might have been addressed as a medical complication becomes, instead, a matter of legal and ethical breach.

This scenario is neither hypothetical nor rare. It reflects a general pattern within healthcare systems where the instinct to manage reputational risk overrides the duty of transparency.

The scale of the issue in Nigeria is reflected in data suggesting that medical errors remain a significant contributor to hospital mortality. Available reports indicate that a substantial proportion of deaths within healthcare settings in developing African contexts, including Nigeria, may be attributable directly or indirectly to medical error.

Notwithstanding established professional and ethical obligations requiring timely and transparent disclosure, a persistent culture of silence continues to characterise parts of the Nigerian medical community. This pattern of non-disclosure extends beyond an ethical failing; it raises serious legal concerns, amounting to a potential violation of fundamental patient rights and a breach of the duty of care owed by healthcare practitioners to those under their treatment.

UNDERSTANDING MEDICAL ERROR

A medical error is commonly defined as the failure of a planned action to be completed as intended, or the use of an incorrect plan to achieve a clinical objective. It encompasses a wide spectrum of conduct, including diagnostic inaccuracies, surgical errors, medication mismanagement, and systemic failures.

These errors may be classified broadly as

- **Error of Execution:** The failure of a planned action to be completed as intended. Example, Administering 50mg of a drug instead of the prescribed 5mg due to a misread chart.

- **Error of Planning:** The use of a wrong plan to achieve a specific clinical aim. Example, deciding to proceed with surgery before obtaining necessary biopsy results.

- **Error of Omission:** Harm resulting from an action that was not taken. Example, Failure to strap a patient into a wheelchair, leading to a fall

- .**Error of Commission:** Harm resulting from the wrong action being taken. Example, Transfusing a patient with the wrong blood group.

- **Near Misses:** Errors that do not cause harm by chance or because they were intercepted. Example, A pharmacist catching a wrong prescription before it reaches the patient.

While not all medical errors result in immediate harm, each carries the potential to undermine the fiduciary foundation of the doctor–patient relationship. Unlike a conventional commercial interaction, this relationship is grounded in trust, candour, and professional integrity.

In Nigeria, diagnostic, surgical, and prescription errors remain the most prevalent categories. A 2025 study conducted in Edo State reported a self-disclosed medical error prevalence of 58.6% among healthcare workers, with medication-related errors accounting for 46.3% of cases. Within this category, dose omissions and incorrect dosage administration continue to be the primary drivers of adverse clinical outcomes.

The deliberate withholding of material information in such circumstances erodes the trust inherent in the doctor–patient relationship and gives rise to significant legal consequence.

THE NIGERIAN REALITY: ERROR WITHOUT DISCLOSURE

Evidence suggests that medical errors remain a significant contributor to adverse patient outcomes within Nigeria. More troubling, however, is the persistence of what may be described as a "culture of non-disclosure."

Recent cases have highlighted both individual and systemic failures. In a widely reported 2006 incident, an infant contracted HIV following a blood transfusion at Lagos University Teaching Hospital, notwithstanding that both parents were HIV-negative. A subsequent Federal Government investigation identified systemic lapses and recommended disciplinary action against senior officials.

More recently, in 2026, the Kano State Hospitals Management Board confirmed a case of medical negligence involving the retention of surgical scissors in a patient's body, which resulted in her death and prompted disciplinary proceedings. Other reported incidents ranging from medical negligence resulting to multiple surgical procesdures to denial of emergency careunderscore recurring lapses in both clinical practice and institutional accountability.

MECHANISMS OF CONCEALMENT

Medical Practitioners utilize several strategies to ensure that the facts of an error do not reach the patient. Non-disclosure is rarely overt. It is often facilitated through a range of institutional and professional practices, including:

• **Settlement without admission of liability:** Medical facilities often utilize cash or non-cash considerations to silence victims of medical errors before cases can reach a courtroom. While this may provide immediate financial relief, it prevents systemic learning and protects the image of the institution at the expense of public transparency.

• **Alteration or manipulation of medical records**: In some instances, hospital staff may re-write, change, or destroy original medical records to remove evidence of negligence.

• **Partial or evasive disclosure**: Doctors may provide answers that are technically true but avoid the core facts of the error, such as informing a family of "complications" without admitting those complications were caused by a misdiagnosis or a surgical slip.

• **Restricted access to medical records:** By creating bureaucratic hurdles, hospitals often prevent patients from reviewing their own charts, making it impossible for them to detect any medical error or negligence.

• **Conspiracy Of Silence:** One of the common behaviors on part of the doctors, nurses, and hospital administrators is that when a patient dies or gets seriously injured due to medical errors, individuals who were not directly involved in the treatment will also maintain silence and attempt to cover up the obvious errors committed by their colleagues. They all unite in defense of their common interests.

These mechanisms not only undermine accountability but also perpetuate a cycle in which errors are repeated rather than addressed.

LEGAL FRAMEWORKS: EXISTING PROTECTIONS AND LIMITATIONS

Nigeria's legal system provides a framework for patient protection, though it stops short of imposing an explicit statutory duty of disclosure.

• **Constitutional Protections:** The Nigerian Constitutionguarantees the right to life (Section 33) and the right to the dignity of the human person (Section 34). Furthermore, Section 39(1) provides for the freedom to receive ideas and information without interference. Judicial interpretation confirms that information regarding one's own health status is a fundamental entitlement.

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• **The National Health Act (NHA) 2014:** The NHA 2014 set standards for rendering health services and explicitly protects user rights. Section 20(1) - Prohibition of refusing emergency medical treatment for any reason, Section 23 - Mandatory requirement for providers to give patients relevant information about their health status and Section 28 provides for Right of patients to access their medical records.Violations of Section 20 carry criminal sanctions, including a fine of ₦100,000 or imprisonment for up to six months.

• **The Medical and Dental Practitioner's Act:** The Medical and Dental Practitioners Act establishes the Medical and Dental Council of Nigeria (MDCN) as the principal regulatory body responsible for regulating medical and dental practice in Nigeria. The Council sets standards for training, competence, and professional conduct, and enforces these through disciplinary mechanisms. While the Act does not expressly impose a statutory duty of disclosure, the applicable rules of professional conduct aligned with international standards support an expectation of honesty and transparency, including the disclosure of material medical errors.

• **The Patients' Bill of Rights (PBoR) 2018:** The PBoR consolidates and articulates patient rights derived from existing legal and regulatory frameworks within Nigeria's healthcare system. It outlines a set of fundamental rights, including the right to receive relevant, accurate, and timely information about one's health condition in a language and manner that is understandable. Importantly, this right extends to information concerning treatment outcomes, risks, and complications. In practical terms, this encompasses the disclosure of material medical errors, thereby reinforcing the principle that patients are entitled to full and transparent information necessary for informed decision-making.

COMPARATIVE PERSPECTIVE: THE DUTY OF CANDOUR

• **The United Kingdom:** The Statutory Duty of Candour. The UK's Regulation 20 of the Health and Social Care Act 2014 created a legal requirement for openness and honesty. When things go wrong, providers must apologize and provide a true account. However, a 2025 review revealed that only 23% of stakeholders believe it is consistently followed due to institutional instincts toward concealment.

• **Australia: Privacy and ADM Notifications.** Australia updated its Privacy Act 1988 in 2024 and 2025 to include new obligations regarding automated decision-making (ADM). If a decision is made via an automated system, the provider must notify the individual. This is relevant to Nigeria's digital transition regarding the role of AI in medical errors.

REFRAMING NON-DISCLOSURE: A LEGAL AND ETHICAL BREACH

Non-disclosure of medical error should not be treated or regarded as a mere professional lapse. It represents:

• A breach of fiduciary duty.
• A violation of patient autonomy.
• A potential infringement of constitutional rights; and
• A failure of institutional accountability.

Without transparency, patients are denied the information necessary to make informed decisions, seek appropriate remedies, or prevent further harm.

RECOMMENDATIONS

a. For Policymakers

• Introduce a statutory duty of candour: Enact legislation imposing a clear legal obligation on healthcare providers to disclose material medical errors, with appropriate sanctions for non-compliance.

• Strengthen professional regulation: Amend the Medical and Dental Practitioners Act to expressly classify non-disclosure as professional misconduct.

• Mandate professional indemnity insurance: Require practitioners to maintain adequate insurance cover to support timely and fair compensation for affected patients.

b. For Practitioners and Institutions

• Embed disclosure practices: Provide structured training to enable practitioners communicate errors with clarity, empathy, and professionalism.

• Adopt safe reporting systems: Establish internal, non-punitive reporting frameworks that prioritise systemic improvement over individual blame.

• Ensure access to records: Remove administrative barriers that restrict patient access to medical information.

CONCLUSION

Medical error may be inevitable; concealment is not.

Nigeria's healthcare system now faces a fundamental choice not between perfection and failure, but between silence and accountability. Where silence prevails, trust is diminished; where transparency is embraced, confidence can be restored.

The transition to a culture of candour is therefore not merely desirable but necessary. It is essential not only for regulatory compliance, but for the protection of patient dignity, the preservation of trust, and the advancement of justice within healthcare delivery.

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