

“RECONSTRUCTING MEDICAL NEGLIGENCE FOR AI-DRIVEN CARE: TOWARD A NIGERIAN STANDARD OF REASONED JUSTIFICATION”

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Abstract

Artificial intelligence (AI) is rapidly reshaping clinical judgment in Nigeria, yet it operates within a medico-legal framework designed for exclusively human decision-making. Existing negligence doctrines, *Bolam*, *Bolitho*, *Montgomery*, and their Nigerian articulation in *Okonkwo v Medical and Dental Practitioners Disciplinary Tribunal*, remain foundational but insufficient for hybrid human–machine clinical environments. As AI systems increasingly influence diagnosis, triage, and treatment, responsibility becomes distributed across clinicians, hospitals, and developers, exposing gaps in duty of care, causation, consent, and institutional accountability. This article argues that Nigerian health law must evolve from professional deference to reasoned accountability grounded in both constitutional values and African bioethics.

To address these emerging gaps, the article proposes the Standard of Reasoned Justification (SRJ), a four-pillar normative framework, empirical competence, logical defensibility, respect for autonomy, and institutional responsibility, rooted in *Okonkwo*’s mandate that practitioners act “competently, conscientiously, and guided by reason.” The SRJ provides a unified standard for evaluating AI-mediated clinical decisions, bridging doctrinal evolution with modern demands for transparency, explainability, and patient-centred governance.

The article demonstrates how AI challenges existing statutory regimes, including the National Health Act 2014, the Medical and Dental Practitioners Act, and the Nigeria Data Protection Act 2023, and identifies the structural weaknesses of Nigeria’s fragmented regulatory ecosystem. It concludes by recommending legislative and institutional reforms, including amendments to the Evidence Act 2011 and the National Health Insurance Authority Act 2022, and the establishment of a National Health Artificial Intelligence Governance Framework. Together, these measures would embed the SRJ into Nigeria’s legal order,

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ensuring that technological innovation remains accountable to the constitutional imperatives of dignity, autonomy, and justice.

Keywords: medical negligence; artificial intelligence; Nigeria; Standard of Reasoned Justification; Evidence Act s 84; SaMD; NHIA accreditation; ubuntu; autonomy; algorithmic accountability.

1. Introduction: The AI Disruption of Medical Judgment in Nigeria

Artificial intelligence is advancing rapidly within Nigerian healthcare, transforming clinical decision-making while revealing persistent gaps in negligence doctrine and data governance. Building on the author's earlier analysis of *Bolam v. Friern Hospital Management Committee* (1957), *Bolitho v. City and Hackney Health Authority* (1998), and *Montgomery v. Lanarkshire Health Board* (2015), which track the doctrinal shift from professional deference to reason-based accountability, this article extends that trajectory to AI-mediated care. It argues that clinical legitimacy must now rest on a unified standard of reasoned justification across human and algorithmic decisions. The article proposes the Standard of Reasoned Justification (SRJ) to embed empirical competence, logical defensibility, and respect for autonomy within institutional responsibility.

Yet the rapid adoption of AI exposes doctrinal spaces that Nigerian negligence law was never designed to govern. Core statutes such as the Medical and Dental Practitioners Act (2004) and the Code of Medical Ethics in Nigeria (Medical and Dental Council of Nigeria, 2022) still assume that clinical judgment is exclusively human, leaving no framework for assessing the reasonableness of algorithmic recommendations. Because AI distributes decision-making across clinicians, institutions, and developers, the traditional model of individual fault is structurally incapable of allocating liability or ensuring patient protection. These gaps illustrate the urgent need for a unified standard capable of evaluating both human and machine-assisted decisions.

Nigeria's health system is innovating under conditions of strain. Workforce shortages, uneven digital infrastructure, and fragmented data systems slow diagnosis and impair coordination. To cope, hospitals and diagnostics centres increasingly deploy AI systems for triage support, imaging interpretation, and predictive modelling. As these tools shape clinical judgments, accountability becomes dispersed across clinicians, software developers, and institutions, even though governing frameworks, such as the Medical and Dental Practitioners Act (2004) and the Code of Medical Ethics (Medical and Dental Council of Nigeria, 2022), continue to assume a human decision-maker. This widening gap between technological

capability and legal oversight makes it urgent to rethink duty of care, informed consent, and liability for an AI-driven clinical environment.

Artificial intelligence is already reshaping the practice of medicine. It sharpens diagnostic accuracy, anticipates risks, and streamlines routine administrative and clinical tasks. In Nigeria, where delayed diagnoses, limited staffing, and siloed clinical data remain everyday barriers, these innovations could significantly strengthen clinical performance. Yet the promise of AI is tempered by the reality that existing legal, ethical, and institutional frameworks have not kept pace with the technology. Healthcare law still regulates human actors, not algorithms; data governance frameworks regulate personal data but not automated inference; and clinical standards remain grounded in human professional judgment rather than hybrid, machine-supported reasoning.

Nigerian medical negligence doctrine inherits the English common-law template. Under *Bolam* (1957), a clinician is not negligent if acting in accordance with a practice accepted by a responsible body of medical opinion. *Bolitho* (1998) refined this by permitting courts to reject expert testimony that fails logical scrutiny. The Supreme Court in *Montgomery* (2015) later shifted the standard toward patient-centred disclosure and autonomy. Nigerian jurisprudence has incorporated these principles, most notably in *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999), which emphasised competence, conscientiousness, and respect for informed choice. Together, these authorities form the doctrinal foundation against which AI-mediated clinical decisions must now be justified.

However, these human-centred standards now face an unprecedented test. AI introduces decision pathways that are statistical rather than intuitive, collective rather than individual, and frequently opaque even to their developers. When diagnostic or treatment recommendations derive from algorithmic reasoning, the *Bolam* assumption of medical-professional control becomes unstable. Courts can no longer assess negligence solely by comparing a clinician's judgment with that of peers; instead, the central question becomes whether reliance on a given AI system was itself reasonable. In this emerging landscape, the principles of logical defensibility (*Bolitho*, 1998) and meaningful disclosure (*Montgomery*,

2015) must evolve to assess both human conduct and the transparency, validity, and ethical deployment of machine intelligence.

These challenges are amplified by gaps in Nigeria's data-governance regime. The National Health Act (2014) recognises rights to information, consent, and confidentiality but contains no provisions on automated processing or algorithmic decision-making. The National Health Insurance Authority Act (2022) encourages digital platforms but does not address the ethical governance of AI-driven analytics. The Nigeria Data Protection Act (2023) secures privacy rights but remains largely silent on algorithmic transparency, fairness audits, and requirements for meaningful human oversight. The result is a rapidly expanding digital-health ecosystem, spanning NITDA frameworks, NHIA systems, and NCDC surveillance platforms, operating in a regulatory vacuum.

These gaps pose difficult jurisprudential questions. Can a clinician satisfy the duty of care by relying on an opaque algorithm? What does informed consent mean when neither clinician nor patient can explain how the model reached its conclusions? When harm results from an algorithmic recommendation, where does liability fall, on the clinician, the developer, or the institution that deployed the system? Meeting these challenges requires a shift from after-the-fact negligence review to proactive, risk-based governance.

Beyond conceptual uncertainties lie practical gaps. Algorithmic bias can reproduce or amplify existing social inequities, yet Nigeria's general constitutional protections for equality and dignity are too abstract to regulate automated decision systems. Assigning liability becomes more complex when responsibility is distributed across multiple actors. These realities demonstrate that traditional doctrines of fault, causation, and responsibility are insufficient for governing AI-driven healthcare.

Recent Nigerian scholarship highlights the regulatory vacuum surrounding AI in clinical practice. Ehirim (2025) identifies persistent gaps in patient-safety protections and informed-consent processes, while Akinpelu and Akintola (2023) outline the ethical and legal risks of bias, discrimination, and liability associated with AI-enabled care. These analyses map the landscape but do not articulate a doctrinal test for adjudication. Building on these

insights, this article advances the SRJ as a normative framework that transforms medical accountability into a logic-based, rights-conscious standard suitable for evaluating both human and algorithmic decision-making.

The SRJ extends the *Bolitho* requirement of logical defensibility to algorithmic reasoning, empirical validation, and institutional oversight. It grounds legitimacy in four mutually reinforcing pillars: empirical competence (validated evidence and reliable tools), logical defensibility (transparent and coherent reasoning), respect for autonomy (genuine patient understanding and meaningful choice), and institutional responsibility (robust governance, audit, and redress mechanisms). Embedded within Nigeria's hybrid legal environment, the SRJ harmonises statutory duties under the National Health Act (2014), ethical standards in the Code of Medical Ethics (Medical and Dental Council of Nigeria, 2022), and constitutional principles of dignity and fairness. Together, these dimensions shift health law from reactive negligence litigation to proactive, principled governance.

This article adopts a doctrinal-normative methodology, analysing Nigerian statutes and case law (e.g., National Health Act, 2014; NDPA, 2023; NHIA Act, 2022; Evidence Act, 2011; *Bolam*, 1957; *Bolitho*, 1998; *Montgomery*, 2015; *Okonkwo*, 1999), drawing on African bioethics, and engaging comparative regulatory instruments such as the WHO (2021) AI ethics guidance and the EU Artificial Intelligence Act (European Union, 2024). The sections that follow develop this framework systematically.

2. Legal Foundations of Clinical Decision-Making in Nigeria

The regulation of medical decision-making in Nigeria draws heavily from English common law, where judicial precedent, rather than statute, governs negligence and professional liability. The underlying assumption is that medical reasoning is human reasoning: clinicians exercise judgment informed by expertise, experience, and ethics. Artificial intelligence (AI) unsettles this premise and exposes doctrinal gaps in how responsibility and reasoning are conceived within Nigerian health law.

2.1. *The Bolam Paradigm and Professional Deference*

The landmark case of *Bolam v. Friern Hospital Management Committee* (1957) established that a doctor is not negligent if acting in accordance with a practice accepted as proper by a responsible body of medical opinion, even if others disagree. This rule entrenched judicial deference to professional consensus, a principle long embraced by Nigerian courts. In *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999), the Supreme Court affirmed that practitioners must meet “the standard of care reasonably expected of a competent practitioner in that field.”

However, the *Bolam* test has been criticised for allowing the profession to define its own standards, producing what commentators call “paternalism by proxy.” In Nigeria, where independent expert testimony is scarce, this deference often makes negligence claims unsustainable without insider support. In the AI era, such deference becomes untenable: the “responsible body of opinion” may no longer comprise clinicians but algorithmic systems designed by software developers. The next judicial development, *Bolitho v. City and Hackney Health Authority* (1998), directly responded to this weakness by demanding that professional opinion itself be rational and defensible.

Nigerian anchoring in *Okonkwo*. Although *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999) does not cite *Bolitho* (1998) or *Montgomery v. Lanarkshire Health Board* (2015) by name, the Supreme Court’s reasoning tracks their core commitments. In *Okonkwo*, the Court overturned disciplinary sanctions where the physician respected a competent adult’s refusal of treatment on moral or religious grounds, holding that autonomy, informed choice, and good faith delimit professional judgment. The Court rejected paternalism and affirmed that a doctor’s discretion must be competent, conscientious, and guided by reason, while respecting a capacitated patient’s informed choice even where that choice carries material risk. In doctrinal terms, *Okonkwo* internalises the logical justification of clinical decisions (the spirit of *Bolitho*, 1998) and patient-centred disclosure and self-determination (the logic later crystallised in *Montgomery*, 2015). This is the domestic foundation on which the SRJ rests: empirical competence and respect for autonomy, exercised in good faith and open to scrutiny.

2.2. *The Bolitho Refinement: Logical Defensibility*

The decision in *Bolitho v. City and Hackney Health Authority* (1998) introduced a vital corrective: professional opinion must withstand logical scrutiny. Courts may reject expert testimony if it lacks a rational foundation. Nigerian disciplinary tribunals and appellate courts have echoed this stance, for example in *Medical and Dental Practitioners Disciplinary Tribunal v. John*, where both the tribunal and the appellate court held that medical conduct must be justified by science and logic, not by habit or hierarchy. The tribunal rejected an expert defence based on habit rather than science, affirming that acceptable practice must be rationally justified, an approach consistent with *Bolitho* (1998).

This shift from professional deference to logical defensibility parallels the modern logic of algorithmic accountability. AI-generated recommendations must be explainable, open to human scrutiny, and capable of rational justification. When algorithms function as opaque “black boxes,” they risk failing *Bolitho*’s test of logical defensibility. Thus, *Bolitho* foreshadows today’s jurisprudential demand for explainable AI and reason-giving as a legal standard. The insistence on logical justification also reframes how Nigerian courts may assess the reliability of algorithmic reasoning. Nigerian courts have travelled the same path: in *Okonkwo* (1999), clinical discretion was upheld only when exercised conscientiously and with respect for informed choice.

2.3. *Informed Consent and the Duty to Disclose*

Informed consent remains the cornerstone of patient autonomy in Nigerian law. Section 23 of the National Health Act (2014) guarantees patients the right to be informed of their health status, proposed treatment, and associated risks. The Code of Medical Ethics in Nigeria reinforces that consent must be both voluntary and informed (Medical and Dental Council of Nigeria, 2022). Nigerian scholars have similarly emphasised that genuine consent requires comprehension, not mere signature.

Yet AI complicates this process. Patients may be unaware that part of a clinician’s decision derives from automated analysis, and clinicians may lack the technical understanding to explain how the algorithm reached its conclusion. When disclosure becomes

impossible, consent risks devolving into ritual, a concern highlighted in *Montgomery v. Lanarkshire Health Board* (2015), which ties valid consent to understanding and personal choice. Nigerian law must therefore broaden informed-consent doctrine to include algorithmic transparency: disclosure not only of risks but also of the technological reasoning underpinning care decisions. The statutory framework reveals how fragile these principles remain when confronted with digital systems.

The shift toward patient-centred disclosure in *Montgomery v Lanarkshire Health Board* (2015) reflects a broader common-law trajectory visible in *Reibl v Hughes* (1980) in Canada and *Rogers v Whitaker* (1992) in Australia, both of which frame consent around material risks from the patient's perspective rather than professional custom. This trajectory reinforces the need for Nigerian law to interpret Section 23 of the National Health Act and the MDCN Code in a manner consistent with autonomy and understanding in AI-mediated care.

2.4. *Statutory and Institutional Framework*

Nigeria's key statutory instruments, the Medical and Dental Practitioners Act (2004), the National Health Act (2014), and the National Health Insurance Authority Act (2022), all presume a human decision-maker at the centre of medical practice. None explicitly address algorithmic systems or digital decision support. Likewise, the Evidence Act (2011) contains only rudimentary provisions for electronic records and does not contemplate algorithmic audit logs or model explainability. This leaves both patients and practitioners vulnerable: patients face difficulty proving fault, while clinicians risk liability for outcomes partly generated by AI tools they cannot interrogate.

By contrast, jurisdictions such as South Africa and Kenya have begun to integrate data-governance principles into health regulation. South Africa's Protection of Personal Information Act (2013) and Kenya's Data Protection Act (2019) emphasise accountability and transparency in automated processing, signalling a more explicit recognition of algorithmic risks. The absence of equivalent safeguards in Nigeria widens the gap between technological innovation and legal protection.

2.5. *From Professional Deference to Reasoned Accountability*

Over time, Nigerian medical law has gradually evolved from deference to accountability. *Okonkwo* (1999) and subsequent decisions signal a shift toward reasoned justification, requiring practitioners to defend clinical choices on logical, ethical, and empirical grounds. AI extends this duty: both human and digital actors must now meet a shared threshold of reasonableness anchored in transparency, defensibility, and ethical oversight. The next section examines how AI disrupts existing liability frameworks and compels this doctrinal evolution toward shared accountability in healthcare.

3. The AI Challenge: Delegated Judgment and Shared Liability in Nigerian Healthcare

Artificial intelligence (AI) is no longer a futuristic abstraction in Nigeria's health sector. Machine-learning tools now support radiological diagnostics, electronic prescribing, infectious-disease surveillance, and hospital management systems. By mediating, or even supplanting, human reasoning, AI blurs traditional boundaries of clinical responsibility. Nigerian negligence law, still anchored in the *Bolam* standard, presumes a direct causal link between a practitioner's judgment and patient harm. In AI-mediated care, however, decision-making becomes distributed across clinicians, institutions, developers, and regulators, each contributing to outcomes, but none solely accountable.

3.1. *AI as a Co-Decision-Maker*

AI systems increasingly act not merely as assistive tools but as inferential and decision-generating systems. Predictive algorithms deployed by the Nigeria Centre for Disease Control (NCDC) for epidemic modelling and by private telemedicine platforms for triage directly influence treatment pathways (NCDC, 2022). The clinician's discretion is shaped by algorithmic outputs, producing a hybrid model of clinical decision-making. When these outputs prove erroneous, attributing negligence under traditional doctrines becomes difficult because responsibility no longer maps neatly onto human agency.

3.2. *Diffused Duty of Care*

In negligence law, the duty of care is typically personal and relational (Adewale, 2020). AI introduces a triadic structure of responsibility:

- Clinician–Patient Duty – the clinician’s obligation to interpret, verify, and critically assess AI outputs.
- Institution–Patient Duty – the hospital’s duty to procure, validate, maintain, and supervise AI systems responsibly.
- Developer–User Duty – the software provider’s duty to design algorithms that are safe, explainable, and resistant to bias.

Currently, Nigerian law recognises only the first duty. Hospitals are rarely sued for defective digital systems, and developers typically fall outside health-specific regulatory oversight (Okeke, 2023). This asymmetry exposes clinicians to liability for outcomes beyond their control, emphasising the need to reconceptualise the duty of care as shared, networked responsibility.

3.3. *Product Liability and Defective Algorithms*

Under the Federal Competition and Consumer Protection Act (FCCPA, 2018), manufacturers and suppliers bear strict liability for defective products that cause injury. The statute was drafted with tangible consumer goods in mind. Its provisions on defect and fitness for purpose do not easily accommodate adaptive algorithms that update their decision rules after deployment. Consequently, AI decision systems, though capable of causing harm, do not fit comfortably within statutory definitions of “products.”

Similarly, neither the National Agency for Food and Drug Administration and Control (NAFDAC) nor the Standards Organisation of Nigeria (SON) currently certifies software as a medical device. Extending NAFDAC’s jurisdiction to Software as a Medical Device (SaMD) would permit pre-deployment validation analogous to pharmacovigilance (NAFDAC, 2021). This would create a statutory duty of safety for developers, functionally extending the neighbour-principle logic of *Donoghue v. Stevenson* (1932) into digital contexts.

A more immediately workable pathway is institutional negligence under Section 19 of the National Health Act (2014), which obliges every health establishment to “ensure the provision of quality health services.” This duty logically extends to digital infrastructure. When a hospital deploys unvalidated or biased AI systems without adequate oversight, the breach lies not in coding error but in negligent governance. Framed this way, institutional negligence modernises the *Bolam* model by shifting focus from individual professional fault to systemic accountability. This approach aligns with *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999), which emphasises competent, conscientious care, and with global trends recognising organisational responsibility for digital safety.

Sections 120–122 of the FCCPA (2018) impose strict liability for defective products. Extending strict liability to high-risk AI systems under a future Health AI Regulation Bill would incentivise “safety-by-design,” consistent with the SRJ’s empirical-competence and institutional-responsibility pillars.

3.4. *Causation and Evidentiary Challenges*

Proving causation in AI-related medical harm remains a formidable challenge. Algorithms may rely on opaque datasets, undergo continuous retraining, or produce outputs that are difficult to audit. Although the Evidence Act (2011) recognises electronic records as admissible evidence, its provisions centre on conventional computer-generated documents and human-authenticated certificates. These rules do not contemplate dynamic, self-learning systems or the metadata trails essential for algorithmic accountability.

Section 84 of the Evidence Act (2011) admits computer-generated evidence only if accompanied by a human certificate attesting to its integrity. In learning systems, no single individual can credibly certify the entire process. This procedural rigidity renders Section 84 poorly suited to AI-related evidence and underscores the urgency of legislative reform to recognise audit logs, model cards, and metadata as self-authenticating records.

A feasible reform is the introduction of a reverse burden of proof: once harm is plausibly associated with an AI system, the deploying institution must demonstrate compliance with validation, monitoring, and audit obligations. This aligns with precautionary

reasoning in public-health jurisprudence and mirrors European risk-allocation models that assign responsibility to those best positioned to control digital systems (European Union, 2024).

3.5. Institutional and Vicarious Liability

Hospitals integrating AI within electronic medical records effectively embed algorithms into clinical governance structures. Section 19 of the National Health Act (2014) requires health establishments to maintain quality services, which extends to digital systems they deploy. Institutions that integrate unvalidated or biased algorithms may therefore be negligent for failing to ensure safe clinical infrastructure.

Section 24 of the Nigeria Data Protection Act (NDPA, 2023) requires “privacy by design and by default.” AI systems that expose patients to discriminatory or unsafe automated processing could attract both regulatory and civil liability. These obligations collectively establish an emergent form of institutional liability, reflecting the reality that decisions about technology procurement and governance are integral to patient safety.

3.6. Professional Ethics and Oversight

The Code of Medical Ethics in Nigeria requires practitioners to maintain competence and employ scientifically validated methods (Medical and Dental Council of Nigeria, 2022). Ethical oversight therefore requires clinicians to understand, question, and verify AI outputs rather than rely blindly on them. Uncritical dependence would breach professional duties. Institutions also share a complementary obligation to provide training, documentation, and transparency regarding AI systems. Together, these expectations form a dual responsibility: the clinician’s duty of informed oversight and the institution’s duty of technological stewardship.

3.7. Shared Liability and Reform Imperatives

Nigeria’s legal framework must evolve from the individualistic negligence model toward a regime of shared liability among clinician, institution, and developer. Legislative recognition of distributed accountability aligns with Section 17(2)(a) of the Constitution of the Federal Republic of Nigeria (1999), which enshrines social justice and equitable

governance. A dedicated Health Artificial Intelligence Regulation Bill could codify this framework, allocating duties according to control, capacity, and benefit. Such reform would harmonise clinical practice with the principle of reasoned justification that underpins the SRJ model.

4. Ethical Foundations and African Bioethics in AI-Driven Healthcare

Law without ethics risks losing moral legitimacy. In the age of intelligent machines, the ethical compass of healthcare becomes as vital as its legal scaffolding. Nigeria's pluralistic moral landscape, shaped by communal traditions, religious faiths, and constitutional ideals, offers a fertile foundation for ethical AI governance (Metz, 2011; Tangwa, 2000). African bioethics, with its emphasis on solidarity, relational personhood, and responsibility, provides not only a moral framework but also a culturally resonant guide for aligning technological innovation with human dignity (Metz, 2010; Tangwa, 2014).

4.1. Communitarian Ethics and Solidarity

African bioethics locates moral legitimacy in community rather than in isolated individuals. Personhood, in this tradition, is relational and is often captured in the concept of ubuntu, a philosophy of humanity and mutual care summed up in the expression "I am because we are" (Metz, 2011). It embodies mutual care and communal accountability and underpins the idea of relational autonomy in African bioethics. Decisions are evaluated not only by their impact on individuals, but also by their contribution to collective wellbeing. Within this framework, healthcare ethics demands that AI systems serve the social good, preserving trust and solidarity rather than deepening inequality.

Ubuntu, literally "humanity toward others", is not only an ethical aspiration but also a constitutional and legal mandate. Section 17(2)(a) of the Constitution of the Federal Republic of Nigeria (1999) requires the state to promote social justice and equality, while Article 16 of the African Charter on Human and Peoples' Rights guarantees the right to health (African Union, 1981). Embedding ubuntu's communitarian ethic within AI governance therefore transforms the ideal of solidarity into a public-law duty: participatory, inclusive decision-making in digital health becomes a constitutional obligation as much as an ethical one.

This communitarian logic provides an ethical counterweight to Western individualism. Whereas conventional bioethics often privileges autonomy as independence, African thought interprets autonomy as relational self-determination, freedom exercised within moral and social obligations (Tangwa, 2014; Metz, 2010). Ethical AI governance in Nigeria must therefore be participatory and inclusive: communities, not just regulators or developers, should be engaged in decisions concerning data use, algorithmic design, and clinical deployment. Involving patient groups, traditional leaders, and civil society in data-governance deliberations reflects the African ethic of solidarity and echoes global principles of participatory ethics (Ten Have & Gordijn, 2014).

4.2. Autonomy and Dynamic Consent

While Western bioethics prizes autonomy as individual self-determination, African thought reinterprets it as relational autonomy, freedom realised within social bonds and communal responsibilities (Tangwa, 2014). Dynamic consent operationalises this form of autonomy by allowing ongoing, context-sensitive control over data use, consistent with communitarian ethics in which freedom is exercised through mutual responsibility (Metz, 2011). Section 23 of the National Health Act (2014) protects patients' rights to information and informed consent, but genuine consent in AI-driven care also requires transparency about algorithmic involvement, data flows, and automated reasoning.

A dynamic-consent model, in which patients can grant, modify, or withdraw permission for data use and algorithmic participation over time, would give practical effect to this relational view of autonomy. Such an approach balances personal agency with communal accountability, ensuring that consent remains informed, contextual, and continuous rather than a one-off signature. It also resonates with Islamic and Christian ethics, in which moral choice is meaningful only when exercised with understanding and responsibility (Al-Bar & Chamsi-Pasha, 2015).

4.3. Beneficence, Non-Maleficence, and Algorithmic Safety

The twin duties to promote good (beneficence) and avoid harm (non-maleficence) remain central to medical ethics. When AI systems trained on foreign or non-representative

datasets are deployed without local validation, they risk misdiagnosing Nigerian patients due to contextual and epidemiological mismatch. The Code of Medical Ethics in Nigeria explicitly requires that medical methods be “scientifically proven and applicable to our environment” (Medical and Dental Council of Nigeria, 2022).

Validating AI tools on Nigerian data is therefore both an ethical imperative and a statutory duty. Hospitals and regulators must implement algorithmic vigilance analogous to pharmacovigilance, monitoring performance, bias, and safety outcomes throughout a system’s lifecycle (Federal Ministry of Health, 2020). In this respect, ethical governance converges with legal responsibility under the SRJ’s first pillar of empirical competence.

4.4. Justice and Equity

The right to health, guaranteed by Article 16 of the African Charter on Human and Peoples’ Rights and by Section 17(3)(c) of the Constitution of the Federal Republic of Nigeria (1999), demands fairness in healthcare access (African Union, 1981). Artificial intelligence can either bridge or deepen inequities depending on how it is governed. Algorithms trained predominantly on urban, affluent, or foreign populations may reproduce structural exclusion, disadvantaging rural and marginalised communities.

Ethical justice therefore requires proactive measures such as bias audits, inclusive datasets, and equitable deployment across regions. Ministries of Health and Education should prioritise AI literacy and infrastructure in underserved areas to prevent a “digital divide” in the quality of medical care. By embedding distributive justice into technology governance, Nigeria aligns AI deployment with its communitarian ethos, under which collective welfare validates innovation.

4.5. Faith-Informed Ethics

Nigeria’s dominant faith traditions, Islam and Christianity, converge on the sanctity of life, human dignity, and stewardship. In Islamic jurisprudence, the *maqāṣid al-sharī‘ah* (objectives of the law) include preservation of life (*ḥifẓ al-nafs*) and intellect (*ḥifẓ al-‘aql*). Medical technologies are permissible only if they uphold these objectives and promote *maṣlahah* (public welfare) (Al-Bar & Chamsi-Pasha, 2015). Christian moral theology

similarly frames technology as an instrument of stewardship, to be used for healing and service rather than domination.

Both traditions reinforce constitutional rights to life and dignity under Sections 33 and 34 of the Constitution of the Federal Republic of Nigeria (1999) and align with the African Charter's human-centred ethos (African Union, 1981). Framing AI ethics within these moral vocabularies fosters societal legitimacy and anchors regulation in Nigeria's moral consciousness rather than in imported norms alone.

4.6. Embedding Ethics in Regulation

Ethical reflection must precede technological adoption. The National Health Research Ethics Committee (NHREC) should expand its remit to require ethical impact assessments (EIAs) for AI systems, evaluating fairness, transparency, and social consequences prior to approval (NHREC, 2014). Hospitals should establish AI ethics committees or boards to monitor compliance, while professional councils integrate algorithmic ethics and explainability into continuing professional development (Ten Have & Gordijn, 2014).

Institutionalising ethics in this way ensures that moral reasoning is not an afterthought but a condition of innovation. It translates Africa's communitarian moral heritage into governance architecture, aligns with the SRJ's fourth pillar of institutional responsibility, and grounds Nigeria's digital health transformation in justice, empathy, and shared accountability.

5. Regulatory Imperatives and Governance Models for AI in Nigerian Healthcare

Effective governance of artificial intelligence (AI) in healthcare requires coherent institutional coordination, consistent standards for safety and accountability, and a normative commitment to human dignity. Without a unified framework, AI systems risk operating in regulatory silence, advancing faster than the law can respond. Nigeria's health sector already possesses a dense network of regulators, but their mandates remain fragmented, reactive, and largely analog in orientation (Adejumo, 2023).

5.1. *The Fragmented Landscape*

Regulatory authority over digital health in Nigeria is dispersed across overlapping agencies:

- The Federal Ministry of Health (FMoH) oversees national health policy under the National Health Act (2014) but has no AI-specific jurisdiction.
- The Medical and Dental Council of Nigeria (MDCN) regulates practitioners, not technologies (Medical and Dental Council of Nigeria, 2022).
- The National Health Insurance Authority (NHIA) administers digital claims systems with no embedded algorithmic-ethics safeguards (NHIA, 2022).
- The National Information Technology Development Agency (NITDA) and the Nigeria Data Protection Commission (NDPC) supervise data protection under the Nigeria Data Protection Act (2023) but lack health-specific provisions.
- The National Agency for Food and Drug Administration and Control (NAFDAC) and the Standards Organisation of Nigeria (SON) regulate tangible medical devices, not software.

This diffusion of authority produces regulatory blind spots where AI applications may be deployed without validation, audit, or ethical oversight (Okeke, 2023). Fragmentation also creates “responsibility gaps”, situations in which no single body can be held accountable when algorithmic errors cause harm. These gaps call for a consolidated and anticipatory model of governance.

5.2. *A National Health Artificial Intelligence Governance Framework (NHAIGF)*

Nigeria should establish a National Health Artificial Intelligence Governance Framework (NHAIGF) under the FMoH to harmonise standards across the AI lifecycle, design, validation, deployment, and monitoring. The framework would integrate existing laws while filling normative gaps.

Operationally, the NHAIGF should mandate:

- pre-deployment certification using locally representative datasets;

- developer-supplied explainability documentation intelligible to clinicians and patients;
- continuous post-market audit with time-bound recertification; and
- ethical and human-rights impact assessments as conditions for approval.

Such a framework would embed ethical reasoning into regulatory architecture, an operational expression of the SRJ's pillars of empirical competence, logical defensibility, and institutional responsibility.

5.3. The National Health Data and AI Governance Council

To ensure coherence, a National Health Data and AI Governance Council (NHDAIGC) should coordinate all relevant agencies: FMoH, NITDA, NDPC, NHIA, MDCN, NAFDAC, SON, and NHREC. The NHDAIGC could initially be established through ministerial regulation as an interagency council and later formalised through statute for legal continuity.

Beyond technical coordination, such a body would also fulfil constitutional and international obligations. Section 17(2)(a) of the Constitution of the Federal Republic of Nigeria (1999) mandates social justice, while Article 16 of the African Charter on Human and Peoples' Rights guarantees the right to health (African Union, 1981). Establishing the NHDAIGC therefore advances these public-law duties by ensuring that AI governance serves public welfare and equity, not only technological innovation.

The Council would:

- develop joint guidelines for algorithmic validation and data governance;
- harmonise ethics, data protection, and safety regulations;
- establish a shared repository for AI-related risk assessments; and
- advise the National Assembly on emerging legislative reforms.

This collaborative model mirrors international best practices such as the United Kingdom's AI and Digital Regulation Service and Singapore's AI Verify framework, while

grounding oversight in Nigeria's institutional realities (UK Government, 2022; Singapore IMDA, 2023).

5.4. Regulatory Principles

The governance framework should rest on five interlocking principles:

- Accountability by design assigns responsibility and traceability at every stage of development and deployment (Gasser & Almeida, 2017).
- Privacy by design, in line with Sections 24–27 of the Nigeria Data Protection Act (2023), embeds data minimisation, purpose limitation, and governance from the outset (NDPC, 2023).
- Transparency and explainability ensure that models are auditable and interpretable by clinicians and, where appropriate, by patients.
- Safety through local validation mandates testing on Nigerian datasets and explicit reporting of performance and bias metrics before and after deployment (FMoH, 2020).
- Human oversight preserves clinician primacy over care decisions, consistent with Section 23 of the National Health Act (2014), and requires documented escalation when AI outputs conflict with clinical judgment.

The right to health, recognised under Article 16 of the African Charter and Section 17(3)(c) of the Constitution of the Federal Republic of Nigeria (1999), requires equitable access to safe, high-quality healthcare (African Union, 1981). AI governance must therefore ensure fairness, inclusion, and protection against bias. Collectively, these principles reflect the ethical triad of beneficence, autonomy, and justice operationalised through law.

5.5. Professional Regulation

The MDCN and other health professional regulatory bodies should amend their codes of medical ethics. Institutional credentialing should be required for AI tools integrated into clinical workflows, and mandatory reporting of AI-related adverse events should become part of clinical governance. These obligations should extend to the Nursing and Midwifery

Council of Nigeria and the Pharmacists Council of Nigeria to ensure sector-wide accountability.

Professional councils should establish continuing professional development (CPD) modules on algorithmic safety and explainability, aligning with the SRJ's emphasis on empirical competence and informed oversight.

5.6. Institutional and Corporate Liability

Hospitals bear statutory duties under Section 19 of the National Health Act (2014) to maintain service quality. Failure to validate or audit AI systems constitutes institutional negligence. The NHIA could condition hospital accreditation and reimbursement on compliance with AI-governance standards, thereby embedding ethics within financial incentives (NHIA, 2022).

Corporate actors, developers and vendors, should be held jointly liable where algorithmic defects contribute to harm, reflecting product-liability principles under the Federal Competition and Consumer Protection Act (FCCPA, 2018). This integrated liability regime aligns responsibility with control and capacity, discouraging reckless technological deployment while preserving trust in digital medicine.

5.7. Legislative Priorities

Nigeria's legislative architecture must evolve to keep pace with algorithmic medicine. Fragmented provisions across the National Health Act (2014), the Medical and Dental Practitioners Act, and the Nigeria Data Protection Act (2023) leave AI-enabled care largely unregulated. A dedicated Health Artificial Intelligence Regulation Bill should therefore be enacted to provide a coherent statutory foundation.

This Bill should adopt global best practices, drawing on the EU Artificial Intelligence Act (European Union, 2024), to classify health-sector AI systems by risk, mandate pre-deployment certification, require explainability documentation, and institutionalise periodic audits and redress mechanisms. The legislation would give binding legal form to the SRJ's

four pillars of empirical competence, logical defensibility, respect for autonomy, and institutional responsibility.

The NHIA Act (2022) should be amended to make accreditation and reimbursement contingent on adherence to AI governance norms. Tying NHIA participation to ethical and safety certification would ensure that only validated, transparent, and accountable AI systems operate within Nigeria's health ecosystem.

Comprehensive reform should include:

- amending the Medical and Dental Practitioners Act to define AI-assisted practice and clarify reasonable reliance;
- amending the National Health Act (2014) to include digital-health certification, algorithmic transparency, and consent for data use;
- enacting a Health Artificial Intelligence Regulation Bill establishing risk-based categories and enforcement mechanisms consistent with the EU AI Act.

5.8. Enforcement and Public Trust

Enforcement must extend beyond paper compliance. Independent third-party audits, periodic publication of performance metrics, and accessible public-complaint mechanisms will strengthen transparency and legitimacy. Civil-society participation, including patient associations, academic experts, and the media, should be institutionalised through consultative forums (Transparency International, 2021). Trust is the currency of digital healthcare; without openness and accountability, even well-designed regulation may face public resistance.

5.9. Human-Centred Governance

Ultimately, AI regulation must remain human-centred, technology serving life, not the reverse. Ethical governance grounded in transparency, accountability, and community welfare will position Nigeria as a continental model for balancing innovation with justice. In doing so, Nigeria can realise the SRJ vision: law and technology aligned through reasoned justification, empirical competence, and respect for autonomy.

6. Toward a Nigerian Standard of Reasoned Justification (SRJ)

The SRJ is the doctrinal articulation of the *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999) standard when applied to algorithmic decision-making. Artificial intelligence (AI) disrupts the doctrinal and moral assumptions that have long anchored medical accountability. The common law's deference to professional judgment, established in *Bolam v. Friern Hospital Management Committee* (1957) and refined through *Bolitho v. City and Hackney Health Authority* (1998), remains valuable but incomplete once decision-making extends beyond human cognition. Nigeria therefore requires a framework that recognises distributed intelligence while preserving the moral discipline of reasoning. This section articulates the Standard of Reasoned Justification (SRJ), a composite legal-ethical framework that integrates empirical, logical, moral, and institutional duties to guide decision-making in AI-enabled healthcare.

6.1. Conceptual Basis

Doctrinally, *Okonkwo v. Medical and Dental Practitioners Disciplinary Tribunal* (1999) provides the Nigerian articulation of reason-giving and autonomy on which the SRJ builds; normatively, the SRJ generalises those duties to hybrid human-machine decisions. The framework synthesises three normative trajectories that converge within Nigeria's legal and moral order:

- Jurisprudential reasoning. Precedents such as *Okonkwo* (1999) and *Bolitho* (1998) affirm that medical discretion must be reasoned rather than mechanical. Both hold that professional judgment requires justification grounded in competence, conscientiousness, and logic.
- African bioethics. Ethical legitimacy in Nigeria rests on beneficence, transparency, solidarity, and community welfare (Metz, 2010, 2011; Tangwa, 2000). Accountability is relational, rooted in collective wellbeing, not individual autonomy alone.
- Public-law governance. Nigerian constitutional thought conceives accountability as justification: state and institutional actions must be explainable to those affected (Constitution of the Federal Republic of Nigeria, 1999).

Together, these traditions establish a unified compass for human and algorithmic reasoning: a decision is legitimate only if it is empirically competent, logically defensible, respectful of autonomy, and institutionally responsible. In synthesising doctrine, ethics, and governance, the SRJ shifts medical accountability from professional deference to public justification, ensuring that reasoning, not automation, remains the benchmark of legitimacy.

By internalising the Supreme Court’s tripartite test of competence, conscientiousness, and reason in *Okonkwo* (1999), the SRJ emerges not as a foreign framework but as the logical extension of Nigeria’s own constitutional and professional duties.

Existing Nigerian scholarship diagnoses important gaps but does not articulate an adjudicative standard. Ehirim (2025) identifies serious risks for patient safety and informed consent under AI-assisted care but does not specify how courts should evaluate AI-mediated decisions. Akinpelu and Akintola (2023) map the ethical and legal risks of bias, discrimination, and liability but do not propose a unified test for allocating responsibility in hybrid decision-making.

The SRJ fills this gap by offering a four-pillar, rights-grounded standard, empirical competence, logical defensibility, respect for autonomy, and institutional responsibility, linking the doctrinal evolution from *Bolam* through *Bolitho* and *Montgomery* (2015) to *Okonkwo*, and adapting it to the accountability challenges of AI-driven care.

6.2. *Elements of the Standard*

The Supreme Court’s formulation in *Okonkwo* , that a practitioner must act “competently, conscientiously, and guided by reason” , mirrors the four pillars of the SRJ. “Competent” aligns with empirical competence; “guided by reason” with logical defensibility; “conscientious” with respect for autonomy; and institutional compliance with Section 19 of the National Health Act (2014) with institutional responsibility. The SRJ thus arises as an inevitable extension of Nigeria’s jurisprudence, not an imported doctrine.

The four pillars also reflect Nigeria’s constitutional and human-rights commitments:

- Empirical competence operationalises the right to health under Article 16 of the African Charter on Human and Peoples' Rights (African Union, 1981), requiring evidence-based and locally validated AI-assisted decisions.
- Logical defensibility advances constitutional guarantees of fairness by ensuring decisions, human or algorithmic, are rational, explainable, and open to review (*Bolitho*, 1998).
- Respect for autonomy is grounded in *Montgomery v. Lanarkshire Health Board* (2015) and reinforced by Section 23 of the National Health Act (2014) and the consent requirements of the Nigeria Data Protection Act (2023).
- Institutional responsibility embodies constitutional values of dignity and accountability under Section 17(2)(a) of the 1999 Constitution, requiring hospitals to organise and supervise health services, including digital systems, in ways that protect human dignity.

6.3. *Empirical Competence*

Decisions must rest on reliable and verifiable evidence. Section 20(1) of the National Health Act (2014) and Section 33 of the Constitution protect professional standards and the right to life. In AI-driven medicine, empirical competence requires local validation, adaptive calibration, and transparent reporting of performance metrics. Reliance on untested or imported algorithms breaches both the ethical duty of beneficence and the legal duty of care (FMoH, 2020).

6.4. *Logical Defensibility*

Borrowing from *Bolitho* (1998), decisions must withstand rational scrutiny. AI systems must therefore be explainable, with reasoning chains accessible for clinical and judicial review. Clinicians incur liability only where they rely uncritically on opaque outputs or ignore conflicts between algorithmic recommendations and clinical judgment. Where institutions deploy non-explainable systems, they bear primary responsibility for resulting harm.

6.5. Respect for Autonomy

Autonomy, protected under Section 23 of the National Health Act (2014) and the MDCN Code of Medical Ethics (Medical and Dental Council of Nigeria, 2022) , requires disclosure of medical risks and AI involvement.

The Nigeria Data Protection Act (2023) requires specific, informed, and freely given consent. In digital care, this evolves into dynamic consent, enabling patients to review, adjust, or withdraw their data and algorithmic participation. Patients must retain the right to human review of automated decisions.

6.6. Institutional Responsibility

Institutions must ensure ethical governance through oversight, validation, and transparency. Section 19 of the National Health Act (2014) mandates hospitals to maintain service quality, which includes algorithmic safety. Institutional responsibility includes:

- maintaining algorithmic audit trails;
- conducting periodic ethical and safety reviews;
- enabling complaint and redress mechanisms.

This pillar grounds the SRJ in Nigeria’s communitarian ethic and constitutional commitment to collective welfare.

6.7. Application and Enforcement

The SRJ functions across three domains:

- Regulatory: adoption by MDCN, NITDA, NDPC, and FMoH as a benchmark for licensing and certification;
- Judicial: recognition by courts as a composite standard of reasonableness in AI-related negligence and data-governance cases;
- Institutional: operationalisation through hospital AI-oversight committees responsible for validation, training, monitoring, and risk mitigation.

This multi-level structure transforms the SRJ into a practical governance tool bridging ethics and enforceable law.

6.8. Benefits of the SRJ

The SRJ offers several advantages:

- **Clarity:** defines measurable duties for human and algorithmic actors.
- **Balance:** distributes responsibility among clinicians, institutions, and developers.
- **Adaptability:** accommodates evolving technologies through principle-based reasoning.
- **Cultural fit:** reflects Nigeria's plural moral traditions, communitarian, religious, and constitutional.
- **Judicial utility:** provides courts with an analytical structure for AI-related negligence and consent disputes.

These attributes make the SRJ both contextually Nigerian and globally relevant.

6.9. Implementation Challenges

Implementation faces structural and capacity constraints: regulatory fragmentation, low digital literacy, limited local datasets, and underdeveloped technical infrastructure. Overcoming these requires investment in judicial education, medical AI training, and research infrastructure. Cross-sector partnerships, among universities, regulators, industry, and civil society, can support local algorithm development and ethical-AI research (Adewale, 2022). National repositories for algorithmic validation, curated by FMoH, NITDA, and NHIA, would reduce reliance on foreign datasets and enhance epistemic independence.

6.10. Normative Implications

The SRJ restores reasoning as the essence of accountability. Legitimacy in healthcare arises not from professional deference or machine precision but from the capacity to explain and justify decisions. Law thereby re-centres conscience within cognition, bridging algorithmic efficiency with moral deliberation.

By embedding empirical competence, logical defensibility, respect for autonomy, and institutional responsibility into a unified normative matrix, the SRJ reconciles Nigerian legal tradition with its ethical heritage. It ensures that, even in the age of artificial intelligence, health law continues to protect human life, dignity, and justice.

Together, these elements translate Nigeria’s medico-legal evolution into a structured model of accountability. Tables 1 and 2 (below) summarise the jurisprudential trajectory culminating in the SRJ, consolidating doctrinal, ethical, and institutional reasoning into a single evaluative framework.

Doctrine / Case	Core Judicial Principle	SRJ Pillar Reflected	Nigerian Relevance
<i>Bolam v Friern Hospital Management Committee</i> [1957] 1 WLR 582 (QB)	Professional standard of care defined by a “responsible body” of medical opinion; judicial deference to expertise.	Contextual background to Empirical Competence and later rational scrutiny.	Early Nigerian negligence decisions adopted <i>Bolam</i> ’s professional-deference model.
<i>Bolitho v City and Hackney Health Authority</i> [1998] AC 232 (HL)	Expert opinion must be logically defensible; courts may reject illogical professional views.	Logical Defensibility	Anticipates algorithmic explainability as a criterion for medical-AI accountability.
<i>Montgomery v Lanarkshire Health Board</i> [2015] UKSC 11, [2015] AC 1430	Clinicians owe a duty of patient-centred disclosure; autonomy replaces paternalism.	Respect for Autonomy	Reinforces s 23 <i>National Health Act 2014</i> on informed consent and disclosure.
<i>Okonkwo v Medical and Dental Practitioners</i>	Doctors must act competently, conscientiously, and in	Empirical Competence and Respect for	Domestic articulation of reason-giving and patient autonomy;

Doctrine / Case	Core Judicial Principle	SRJ Pillar Reflected	Nigerian Relevance
<i>Disciplinary Tribunal</i> (1999) 9 NWLR (Pt 619) 1 (SC).	good faith, respecting informed refusal.	Autonomy	bridges common law and Nigerian ethics.
Standard of Reasoned Justification (SRJ) (this article)	Legitimacy requires decisions to be empirically competent, logically defensible, respectful of autonomy, and institutionally responsible.	Composite of all four pillars	Provides an indigenous, principle-based model for AI-enabled healthcare governance.

Table 1: Evolution of Doctrinal Standards and Correspondence with Standard of Reasoned Justification (SRJ) Pillars

The progression from professional deference to shared accountability also reflects a broader transformation in the moral and institutional foundations of healthcare governance. This trajectory, from professional dominance to distributed, ethical accountability, is illustrated in Table 2.

Historical Phase	Core Accountability Model	Key Characteristics	SRJ Reinterpretation
1. Professional Deference (<i>Bolam</i> era, 1950s–1980s)	Accountability vested in professional consensus (“responsible body of medical opinion”).	Judicial restraint; minimal patient involvement; expert dominance.	SRJ narrows deference through empirical competence, accountability must rest on validated, transparent evidence.
2. Logical Scrutiny (<i>Bolitho</i> refinement,	Accountability conditioned by	Courts begin to test expert opinion for	SRJ generalises this as logical defensibility,

Historical Phase	Core Accountability Model	Key Characteristics	SRJ Reinterpretation
1990s)	reason and logic, not mere conformity.	rational coherence.	extending scrutiny to algorithmic reasoning.
3. Patient-Centred Accountability (<i>Montgomery</i> and human-rights era, 2010s)	Focus shifts to autonomy and informed consent.	Disclosure, shared decision-making, and dignity dominate the standard of care.	SRJ embeds respect for autonomy while recognising relational, community-based consent.
4. Institutional and Systemic Accountability (<i>Okonkwo</i> and contemporary governance)	Institutions bear responsibility for ensuring ethical, safe practice environments.	Statutory duties (e.g., s 19 <i>National Health Act 2014</i>); emerging regulatory oversight.	SRJ integrates institutional responsibility, mandating oversight, audit, and redress.
5. Distributed and Ethical Accountability (<i>AI and SRJ era, 2020s–future</i>)	Accountability shared among clinician, institution, developer, and regulator.	Algorithmic reasoning, data governance, and ethical transparency determine legitimacy.	SRJ unifies all prior stages into a reason-based, human-centred framework balancing innovation with justice.

Table 2: Evolution of Medical Accountability and its Transformation under the Standard of Reasoned Justification (SRJ)

7. Conclusion

Artificial intelligence offers significant promise for Nigerian healthcare, with the capacity to enhance diagnostic accuracy, efficiency, and resource allocation. Yet, if allowed to mature within legal frameworks built solely for human judgment, AI risks eroding accountability and undermining public trust. The central question is therefore not whether Nigeria should integrate AI into clinical care, but how to govern these technologies in ways that safeguard life, dignity, autonomy, and justice. This article has argued that the most

coherent response lies in reconstructing medical negligence around a Standard of Reasoned Justification (SRJ), a framework that applies a unified principle of reasonableness to both human and algorithmically mediated decisions.

The analysis demonstrates that foundational doctrines, *Bolam*, *Bolitho*, *Montgomery*, and *Okonkwo*, remain indispensable, but they must evolve to address a hybrid model of responsibility distributed across clinicians, institutions, and developers. AI challenges traditional notions of fault and causation in ways that existing negligence and product-liability rules cannot fully capture. At the same time, Nigeria's communitarian moral philosophy and its constitutional commitments to dignity, social justice, and solidarity provide a culturally grounded basis for ethical and rights-respecting AI governance. The SRJ brings these doctrinal and ethical strands together through its four pillars, empirical competence, logical defensibility, respect for autonomy, and institutional responsibility, offering courts, regulators, and professionals a principled framework for evaluating AI-driven care.

Implementing this framework requires engaging realistically with Nigeria's institutional landscape. Regulatory mandates remain dispersed across agencies such as the NDPC, NITDA, NHIA, MDCN, and NAFDAC, whose overlapping responsibilities create gaps, delays, and inconsistencies. Constraints in funding, technical capacity, and judicial expertise further complicate oversight, and private-sector resistance to explainability and auditability threatens transparency. These structural barriers underscore the need for deliberate legislative intervention, coordinated governance, and targeted incentives to ensure that the SRJ becomes operational rather than aspirational.

A coherent reform agenda must therefore combine statutory updates, regulatory coordination, judicial adaptation, and professional reorientation. Legislative action should include a dedicated Health Artificial Intelligence Regulation Bill and amendments to the National Health Act, the Medical and Dental Practitioners Act, the Nigeria Data Protection Act, and especially section 84 of the Evidence Act, to recognise machine-generated audit trails and clarify duties in AI-assisted practice. Regulatory reforms should establish a National Health Artificial Intelligence Governance Framework and a National Health Data

and AI Governance Council to harmonise standards, mandate local validation, and provide coordinated oversight.

Judicial reform should incorporate specialised training on digital causation and may require recalibrating evidential burdens for institutions controlling AI systems. Professionally, AI ethics, data stewardship, and algorithmic safety must be integrated into education, accreditation, and disciplinary processes, with hospitals required to maintain registries and audits of deployed systems. Among these measures, tying NHIA accreditation and reimbursement to compliance with AI-governance standards offers the most effective enforcement lever by embedding the SRJ into financial and operational realities.

AI will not replace doctors, but it will redefine what responsible medical practice requires. The SRJ crystallises Nigeria's constitutional promise of dignity, the professional obligation to reason, and the ethical call of solidarity. By embedding its four pillars within statutory, regulatory, and institutional practice, Nigeria can move toward a jurisprudence of reasoned accountability in which technological sophistication remains bound by the law of conscience, and every act of healing, even when mediated by algorithms, remains justified in reason and guided by humanity.

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