

Emergency Treatment and Physician Liability under Nigeria's Gunshot Act 2017: a Constitutional and Criminal Justice Analysis

Boniface E. Ewulum

Faculty of Law, Nnamdi Azikiwe University, Awka, Anambra State Nigeria,

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ABSTRACT

Purpose— This article examines the legal framework regulating emergency treatment of gunshot victims in Nigeria and identifies why the Compulsory Treatment and Care for Victims of Gunshot Act 2017 has not stopped the practice of demanding police clearance before treatment.

Design/methodology/approach — The study adopts a doctrinal method, analysing the Constitution, the 2017 Act, the National Health Act 2014, the Criminal Code, the Penal Code, the Nigeria Police Act 2020 and the African Charter as domesticated, together with the decisions of the Supreme Court on medical autonomy and the sanctity of life. A functional comparative method is applied to South Africa, Kenya, Ghana and the United States, jurisdictions selected because each has confronted the same conflict between emergency care and administrative or financial gatekeeping.

Findings — Four findings are made. First, the 2017 Act is not free-standing: it duplicates, and is reinforced by, section 20 of the National Health Act 2014, a parallel prohibition on refusal of emergency treatment which the existing literature has largely ignored and which extends beyond gunshot injury. Secondly, the fear of accessory liability which physicians report is legally unfounded, because accessory liability under section 10 of the Criminal Code requires a purpose of enabling the offender to escape punishment, and a physician acting under statutory compulsion cannot possess that purpose. Thirdly, the constitutional foundation of the duty to treat lies not in section 33 alone, whose positive dimension is undeveloped in Nigerian jurisprudence, but in the combined operation of sections 33 and 34 with article 16 of the African Charter, which is justiciable in Nigeria by domestication. Fourthly, the Act contains an unexamined internal conflict: a statute entitled “Compulsory Treatment” sits uneasily with the Supreme Court’s recognition in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* of the right of a competent adult to refuse treatment.

Originality/value — The article is the first to analyse the 2017 Act alongside section 20 of the National Health Act as a single duty-imposing regime, to test the accessory-liability fear against the elements of section 10, and to identify the autonomy problem manifest in the Act’s compulsory framing. It proposes a statutory immunity clause, a digital notification system, and an inter-agency protocol.

Keywords: emergency medical treatment; gunshot victims; physician liability; accessory after the fact; right to health; medical confidentiality; Nigeria.

I. INTRODUCTION

For several decades Nigerian hospitals casually declined to treat persons presenting with gunshot wounds until a police report was produced or a deposit paid. None of these practices was required by any statute required. The practice grew from a mixture of law enforcement expectation, institutional caution and professional uncertainty, and was sustained by a widely held but erroneous belief anchored on harassment by security agencies, that treating a gunshot victim exposed the treating institution to criminal scrutiny.

The consequences were severe and are well documented in the Nigerian press. Victims of armed robbery, communal conflict, terrorism, electoral violence and accidental discharge died of injuries that were survivable, while relatives sought documentation from police stations. The practice

subordinated the preservation of life to an administrative formality that had no legal foundation.

The Compulsory Treatment and Care for Victims of Gunshot Act 2017, assented to in December 2017 and comprising sixteen sections, was enacted to end that practice.¹ It directs every hospital, public or private, to receive and treat a person with a gunshot wound without police clearance and

¹ Compulsory Treatment and Care for Victims of Gunshot Act 2017, assented to in December 2017. The Act comprises sixteen sections. Author’s note: the section numbering of the penal provisions cited at nn 18-21 should be verified against the Gazette text before publication.

without an initial monetary deposit, while imposing on the hospital a duty to notify the nearest police station within two hours of the commencement of treatment.²

Compliance to this Act, has nonetheless remained poor. The death of a Channels Television reporter in Abuja in 2019, following alleged rejection by hospitals, and the death of a gunshot victim in Ibadan in June 2021 after rejection by two hospitals, are among the reported instances that postdate the Act.³ Practitioners continue to report fear of police harassment, uncertainty as to reporting obligations, and apprehension of prosecution as accessories.

This article asks why a statute so clear in its terms has proved so ineffective in its operation, and what should be done. It advances the thesis that the obstacle is neither the inadequacy of the duty nor the reluctance of physicians, but institutional conflict between health institutions, law enforcement and professional regulators, compounded by a legal misapprehension about criminal exposure which the Act itself made no effort to dispel.

Part 2 states the method. Part 3 reviews the existing literature and identifies the gap. Part 4 sets out the theoretical framework. Part 5 establishes the constitutional and human rights foundation. Part 6 analyses the statutory duties, including the neglected parallel duty in the National Health Act 2014. Part 7 addresses medical ethics and confidentiality. Part 8 examines criminal liability, and in particular the accessory question. Part 9 considers the autonomy problem. Part 10 examines the regulatory role of the Medical and Dental Council of Nigeria, and Part 11 the available remedies. Part 12 is comparative. Part 13 states the recommendations, and Part 14 the limitations and conclusion.

II. METHODOLOGY

The study is doctrinal. It proceeds by the systematic identification, analysis and integration of primary legal materials, supplemented by secondary commentary, in order to state the law as it is and to evaluate its understanding.

The primary materials examined are the Constitution of the Federal Republic of Nigeria 1999 (as amended); the Compulsory Treatment and

Care for Victims of Gunshot Act 2017; the National Health Act 2014; the Medical and Dental Practitioners Act; the Criminal Code Act; the Penal Code; the Nigeria Police Act 2020; the Administration of Criminal Justice Act 2015; the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act; and the decisions of the Supreme Court and Court of Appeal bearing on medical treatment, consent and the right to life.

A functional comparative method is applied. South Africa, Kenya, Ghana and the United States were selected on three criteria: each has confronted the identical problem of gatekeeping before emergency care; each has adopted a distinct regulatory technique, respectively constitutional entitlement, constitutional entitlement with statutory elaboration, administrative charter, and federal conditional-funding regulation; and materials in each are accessible in English.

Two limitations must be stated. The study is doctrinal and does not present original empirical data on compliance rates, which would require hospital-level survey work beyond its scope. Secondly, the effectiveness of the Act cannot be finally assessed without such data; the conclusions here concern legal coherence and institutional design, and identify empirical questions for subsequent research.

III. LITERATURE REVIEW AND THE RESEARCH GAP

The existing Nigerian literature on the 2017 Act falls into three groups.

The first is descriptive commentary, largely by practitioners, summarising the Act's provisions and calling for awareness and sensitisation. This body of work is useful in establishing the content of the Act and the existence of non-compliance, but it does not analyse the Act's relationship to other legislation and does not test the legal basis of the fears reported by practitioners.

The second is health-policy scholarship, examining the Act as a public health measure and locating it within the broader work on emergency care capacity in Nigeria. This literature identifies infrastructural constraints but treats the legal questions as settled.

The third is human rights scholarship, treating the Act as an instrument for the realisation of the right to life. This work is doctrinally valuable but tends to assume, rather than establish, that section 33 of the Constitution generates positive obligations of the kind asserted.

Three gaps emerge, and this article addresses each. No study has analysed the 2017 Act alongside section 20 of the National Health Act 2014, although the two impose overlapping duties and the

² *ibid*, ss 1, 2 and 3.

³ See the contemporaneous reports of the deaths of Precious Owolabi (Abuja, July 2019) and Ebenezer Ayeni (Ibadan, June 2021), the latter having been rejected by two hospitals for want of a police report.

latter is broader in scope. No study has tested the accessory-liability fear against the actual elements of section 10 of the Criminal Code, and no study has confronted the conflict between a statute imposing compulsory treatment and the Supreme Court's recognition of the right of a competent adult to refuse it.

IV. THEORETICAL FRAMEWORK

Three frameworks inform the analysis.

The rights-based approach treats access to emergency care as a legal entitlement rather than a discretionary benefit, and imposes on the State positive obligations to establish systems capable of protecting life. On this view the 2017 Act is not a health-sector regulation but an instrument of constitutional implementation.

Public interest theory explains the reporting duty. Mandatory notification reconciles the humanitarian objective of treatment with the collective interest in the detection of firearm offences. The theory also supplies the basis for evaluating that duty: a reporting obligation is justified so far as it serves crime control without impeding treatment, and unjustified so far as it operates as a precondition to care.

Therapeutic jurisprudence examines the effect of legal rules on the behaviour and psychological state of those subject to them. The pre-2017 practice generated fear in both patients and clinicians, and the analysis in Part 8 shows that the fear survived the Act because the Act removed the practice without removing its perceived legal basis. On this framework the appropriate remedy is not further sanction but an express immunity that changes the clinician's perception of risk.

V. CONSTITUTIONAL AND HUMAN RIGHTS FOUNDATIONS

5.1 The right to life

Section 33(1) guarantees the right to life.⁴ Nigerian jurisprudence has developed the provision principally as a prohibition of arbitrary deprivation, and the proposition that it generates positive duties of protection is asserted more often than it is established.

The safer route to the same conclusion is through the sanctity-of-life reasoning of the Supreme Court. In *Esabunor v Faweyathe* the Court upheld the authority of a court, on the application of the State, to authorise the medical treatment of an infant whose parent had refused consent on religious grounds, treating the preservation of the life of a

person unable to decide for himself as a paramount consideration.⁵ The decision establishes that the legal order does not treat the preservation of life as a matter of private discretion where the person at risk cannot protect himself. A patient bleeding from a gunshot wound in a hospital reception is in that position.

5.2 Dignity

Section 34(1) protects the dignity of the human person and prohibits torture and inhuman or degrading treatment.⁶ To leave a critically injured person untreated in a hospital because documentation is absent or a deposit unpaid is, on any ordinary understanding, degrading treatment. The Act reinforces the constitutional standard by providing expressly that a person with a gunshot wound shall not be subjected to torture or to inhuman or degrading treatment by any person or authority, including the police or any security agency.⁷

5.3 The right to health and the African Charter route

Section 17(3)(d), directing the State to provide adequate medical and health facilities, is contained in Chapter II and is therefore excluded from judicial enforcement by section 6(6)(c).⁸ Any argument founded on a constitutional right to health must confront that exclusion.

The route around it is the African Charter. Article 16 guarantees the right to enjoy the best attainable state of physical and mental health and obliges States Parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when sick.⁹ The Charter has been domesticated, and in *Abacha v Fawehinmi* the Supreme Court held that it has the force of law in Nigeria and is enforceable in Nigerian courts, though subordinate to the Constitution.¹⁰ Articles 4 and 5 of the Charter, on life and dignity, operate to the same effect.

⁵*Esabunor v Faweya* (2019) 7 NWLR (Pt 1671) 316 (SC).

⁶ Constitution (n 4), s 34(1).

⁷Compulsory Treatment and Care for Victims of Gunshot Act 2017 (n 1), s 2.

⁸ Constitution (n 4), ss 17(3)(d) and 6(6)(c).

⁹ African Charter on Human and Peoples' Rights, art 16.

¹⁰ African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9, Laws of the Federation of Nigeria 2004; *General Sani*

⁴ Constitution of the Federal Republic of Nigeria 1999 (as amended), s 33(1).

This is the more secure foundation, and it is the one this article adopts: the duty to treat is constitutionally anchored in sections 33 and 34 and given its health-specific content by article 16 of the Charter as domesticated.

5.4 Liberty, privacy and equality

Three further rights are engaged. The Act's requirement that a victim be certified fit by the Chief Medical Director before being invited for police investigation protects both clinical judgment and personal liberty under section 35.¹¹ The reporting duty constitutes a statutory exception to medical confidentiality, and is capable of justification under section 37 as a disclosure required by law and confined to a legitimate public purpose. Further, the prohibition of deposits and clearance requirements advances equal access to emergency care irrespective of means or suspicion.

VI. THE STATUTORY FRAMEWORK

6.1 The duty to treat

The Act obliges every hospital in Nigeria, whether public or private, to receive and accept for immediate treatment any person with a gunshot wound, without requiring a police report and without an initial monetary deposit.¹² The language admits of no institutional discretion, and no condition precedent to treatment survives it.

6.2 The duty to report and the statutory sequence

The hospital must report to the nearest police station within two hours of the commencement of treatment, notify the family or relations of the victim within twenty-four hours of becoming aware of his identity, and keep adequate records of the treatment given.¹³

The sequence is the critical feature and it is frequently inverted in practice. The duty to treat arises on presentation; the duty to report arises on the commencement of treatment. Reporting therefore follows treatment and cannot lawfully

precede or condition it. A hospital which telephones the police and awaits their arrival before commencing treatment has breached the Act, notwithstanding that it has complied with the reporting duty.

6.3 Duties of the police

The Act imposes reciprocal obligations on law enforcement: to render every possible assistance to a person with a gunshot wound and ensure his conveyance to the nearest hospital, to commence investigation into the circumstances of the shooting, and to furnish the hospital with background information concerning the victim.¹⁴ The Act further protects volunteers and helpers, who are entitled to be treated with respect and not to be subjected to unnecessary or embarrassing interrogation or harassment in their genuine attempt to save life.¹⁵

These provisions are as much a part of the Act as the duties imposed on hospitals, and they are almost never enforced. The disparity of enforcement is itself a finding of this study.

6.4 The neglected parallel duty: section 20 of the National Health Act 2014

The literature treats the 2017 Act as though it stood alone. This is not correct. Section 20(1) of the National Health Act 2014 provides that a health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason, and section 20(2) creates an offence punishable by fine or imprisonment or both.¹⁶

Three consequences follow, and each strengthens the position of the gunshot victim.

The duty to provide emergency treatment predated the 2017 Act by three years. The refusals that occurred between 2014 and 2017 were therefore already unlawful, and the 2017 Act did not create the duty but particularised it.

The National Health Act duty is broader in scope. It applies to every emergency, not merely to firearm injury, and to every health worker and establishment. A victim of a road traffic collision, a stabbing or an obstetric emergency has the same entitlement, a point of considerable practical

Abacha v Chief Gani Fawehinmi (2000) 6 NWLR (Pt 660) 228 (SC).

¹¹ Compulsory Treatment and Care for Victims of Gunshot Act 2017 (n 1), provisions relating to certification of fitness by the Chief Medical Director; Constitution (n 4), s 35.

¹² *ibid*, ss 1 and 2.

¹³ *ibid*, s 3 (report within two hours of commencement of treatment; notification of family within twenty-four hours; maintenance of treatment records).

¹⁴ *ibid*, provisions imposing duties on the police to assist, convey, investigate and furnish background information.

¹⁵ *ibid*, provisions protecting volunteers and helpers from unnecessary and embarrassing interrogation.

¹⁶ National Health Act 2014, s 20(1) and (2).

importance which the focus on gunshot wounds has obscured.

It is to be noted that the two statutes are cumulative rather than alternative. A hospital which refuses a gunshot victim commits an offence under both, and a prosecutor may elect on which of the Act to frame a charge. Any reform of the 2017 Act should be undertaken with section 20 in view, and the two provisions should ultimately be harmonised.

VII. MEDICAL ETHICS AND CONFIDENTIALITY

The Code of Medical Ethics in Nigeria requires the practitioner to hold in confidence information acquired in the course of the professional relationship, and to give priority to the welfare of the patient. Confidentiality is not, however, absolute. The National Health Act itself provides for confidentiality of user information and permits disclosure where a law requires it.¹⁷ The reporting duty under the 2017 Act is such a law, and disclosure in compliance with it involves no ethical breach.

It should be noted that two limits should be observed. The duty is to report the fact of admission and treatment, not to furnish a clinical dossier or a statement of the practitioner's suspicions as to how the injury was sustained. Again, the statute does not convert the physician into an investigator: he is not obliged, and ought not, to interrogate the patient as to the circumstances of the shooting, which is the function of the police under the Act's own allocation of duties.

VIII. CRIMINAL LIABILITY AND THE EXTENT OF PHYSICIAN EXPOSURE

8.1 Liability for failure to treat and to report

The Act creates three categories of offence. A hospital which fails to make the required report is liable to a fine of one hundred thousand naira, and every doctor directly concerned is liable to six months' imprisonment or a fine of one hundred thousand naira or both.¹⁸ A person who commits an offence under the Act which causes substantial

physical, mental, emotional or psychological damage to the victim is liable to imprisonment for a term of not less than five and not more than fifteen years, without the option of a fine.¹⁹ Further, any person or authority, including a police officer or other security agent, who stands by and fails to perform a duty under the Act, with the result that a person with a gunshot wound dies unnecessarily, is liable to a fine of five hundred thousand naira or five years' imprisonment or both.²⁰ Where an offence is committed by a corporate body, the head of the organisation may be prosecuted.²¹

There are two observations here. The Act's sanctions bear on police officers as heavily as on clinicians, which is not generally appreciated. Again, the offence of standing by is drafted widely enough to capture the hospital administrator who defers to a police officer's instruction not to commence treatment.

8.2 The accessory question

The apprehension most frequently reported by practitioners is that treating a gunshot victim exposes them to prosecution as accessories after the fact. This fear is legally unfounded, and it is worth demonstrating rather than merely asserting.

Section 10 of the Criminal Code provides that a person who receives or assists another who is, to his knowledge, guilty of an offence, in order to enable him to escape punishment, becomes an accessory after the fact.²² The elements are therefore threefold: an offence committed by the person assisted; knowledge on the part of the assister that the person assisted is guilty of it; and the giving of assistance in order to enable him to escape punishment.

Each element fails in the case of a treating physician.

The patient's guilt is not established and is frequently non-existent. A gunshot victim is at least as likely to be the victim of an offence as its perpetrator, and the physician has no means of determining which. Knowledge, in section 10,

¹⁷ *ibid*, ss 26 and 27, on confidentiality of user information and the circumstances in which disclosure is permitted.

¹⁸ Compulsory Treatment and Care for Victims of Gunshot Act 2017 (n 1): failure to report, fine of N100,000 on the hospital, and six months' imprisonment or a fine of N100,000 or both for the doctor directly concerned.

¹⁹ *ibid*: offence causing substantial physical, mental, emotional or psychological damage, imprisonment for not less than five and not more than fifteen years without the option of a fine.

²⁰ *ibid*: standing by and failing to perform a duty under the Act resulting in unnecessary death, fine of N500,000 or five years' imprisonment or both.

²¹ *ibid*: prosecution of the head of a corporate body.

²² Criminal Code Act, Cap C38, Laws of the Federation of Nigeria 2004, s 10; punishment is prescribed by ss 519 and 520.

means actual knowledge of guilt, not suspicion arising from the nature of the injury.

More fundamentally, the third element cannot be satisfied. The words “in order to enable him to escape punishment” import a purpose. A physician who treats a gunshot wound acts with the purpose of preserving life. That purpose is not merely different from the statutory purpose; it is one the physician is compelled by statute to pursue, both by section 1 of the 2017 Act and by section 20 of the National Health Act.

It would be incoherent for the legal order to compel an act by one statute and criminalise it by another. Compliance with a statutory duty cannot supply the mens rea of an offence, and the physician who reports within two hours has in any event done the opposite of assisting escape: he has notified the police of the patient’s whereabouts.

The Penal Code²³ analysis is to the same effect: the offences of harbouring an offender require an intention to screen him from legal punishment, which is absent for the same reasons.

8.3 Why the fear persists

If the legal position is clear, the persistence of the fear requires explanation. Three factors account for it.

The first is the absence of an express immunity. The Act removes the requirement of police clearance but says nothing to the clinician about his own exposure, and silence in a criminal context is not reassuring.

The second is that the risk practitioners actually fear is not conviction but process — arrest, detention, the seizure of records, the disruption of a practice, and the cost of defending a charge that will ultimately fail. An immunity from conviction does not address a risk located at the investigative stage.

The third is enforcement disparity. Prosecutions of hospitals for refusing treatment are rare; police interference in clinical decision-making is common and attracts no consequence. Clinicians respond rationally to the incentives actually operating.

IX. THE AUTONOMY PROBLEM IN A STATUTE OF COMPULSION

An issue manifest in the Act has not, so far as the author is aware, been addressed in the literature.

The Act is entitled “Compulsory Treatment and Care”, and section 1 directs hospitals to receive and treat. Yet in *Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* the Supreme Court held that the constitutional rights to privacy

and to freedom of thought, conscience and religion embrace the right of a competent adult patient to decline medical treatment, and that a practitioner who respects such a refusal is not guilty of infamous conduct.²⁴

The two propositions require reconciliation. The better view, and the one advanced here, is that the compulsion in the Act is directed at the hospital and not at the patient. The Act removes the institution’s discretion to refuse; it does not remove the competent adult patient’s right to refuse. So construed, the statute and *Okonkwo* stand together, and *Esabunor* supplies the qualification that the position differs where the patient is a child or otherwise incapable of deciding for himself.

The point is not academic. A gunshot victim who is conscious, competent and unwilling to be treated — because treatment entails notification of the police — presents a situation the Act does not address, and in which the hospital is under a statutory duty to treat and a constitutional obligation to obtain consent. An amendment should place this matter beyond doubt.

X. THE ROLE OF THE MEDICAL AND DENTAL COUNCIL OF NIGERIA

The Act does not name the Medical and Dental Council of Nigeria as an enforcement agency, an omission this article regards as significant. The Council is nonetheless central to compliance, since it formulates professional standards, maintains the register, issues ethical guidance, investigates misconduct and, through the Investigating Panel and the Disciplinary Tribunal, imposes sanctions ranging from reprimand and suspension to restriction of practice and striking off.²⁵

A practitioner who refuses emergency treatment in circumstances covered by the Act is therefore exposed to professional discipline in addition to criminal and civil liability, and professional sanction is in practice the swifter and more likely consequence.

The Council should issue national clinical guidance on the management of firearm injury, covering the three phases of, the preservation of evidence such as clothing and projectiles, the conduct of interactions with police officers attending the hospital, the mechanics of the two-hour

²⁴*Medical and Dental Practitioners Disciplinary Tribunal v Okonkwo* (2001) 7 NWLR (Pt 711) 206 (SC), per Ayoola JSC.

²⁵ Medical and Dental Practitioners Act, Cap M8, Laws of the Federation of Nigeria 2004, provisions establishing the Council, the Investigating Panel and the Disciplinary Tribunal.

²³ Section 168 Penal Code

notification, and the limits of disclosure. In the absence of such guidance each institution improvises, which is itself a cause of the inconsistency the Act was meant to end.

XI. REMEDIES FOR NON-COMPLIANCE

Five avenues are available and they are cumulative. Criminal proceedings lie under the penal provisions of the 2017 Act and under section 20(2) of the National Health Act. Constitutional proceedings may be brought under the Fundamental Rights (Enforcement Procedure) Rules 2009 for infringement of the rights to life, dignity, liberty and privacy, with declaratory, injunctive and compensatory relief available. Civil proceedings in negligence lie against hospitals and practitioners where refusal causes injury or death, the statutory duty supplying the standard of care. Professional complaints may be laid before the Council while administrative complaints may be made to the National Human Rights Commission, the Federal or State Ministries of Health, and the Police Service Commission in respect of officers who interfere.

The Act confers jurisdiction in disputes arising under it on the High Court of a State,²⁶ and empowers a court to order the head of an organisation to make good, loss suffered by a victim.

The practical difficulty is that all five routes require the victim or his family to initiate proceedings, at a moment of dire distress and usually without means. No public authority is charged with enforcement on their behalf, and that is the principal reason the Act's sanctions have remained largely theoretical.

XII. COMPARATIVE ANALYSIS

12.1 South Africa: constitutional entitlement

Section 27(3) of the South African Constitution provides that no one may be refused emergency medical treatment.²⁷ The provision is unqualified and stands apart from the progressive-realisation formula governing the other socio-economic rights in section 27, a structural feature deliberately adopted to place emergency care beyond resource-based justification. In *Soobramoney v Minister of Health, KwaZulu-Natal* the Constitutional Court construed the provision, holding that it addresses

the sudden catastrophe requiring immediate remedial treatment rather than ongoing treatment for chronic illness.²⁸

The lesson for Nigeria is structural: the entitlement is constitutional rather than statutory, and is therefore directly enforceable without the need for implementing legislation.

12.2 Kenya: constitutional entitlement with statutory elaboration

Article 43(2) of the Kenyan Constitution provides that a person shall not be denied emergency medical treatment, and the Health Act 2017 elaborates the duty, requiring health providers to provide emergency treatment and creating consequences for refusal.²⁹ Kenya thus combines the South African technique with the Nigerian one, and represents the model closest to what Nigeria should aim at: a constitutional guarantee with statutory particulars.

12.3 Ghana: administrative charter

Ghana's approach rests on the Patients' Charter, which recognises entitlement to emergency care irrespective of ability to pay, supported by ministerial directives to health facilities. The technique is administrative rather than legislative, and its weakness is the corresponding weakness of administrative instruments generally: the entitlement is not directly enforceable in the way a statutory or constitutional right is.

12.4 United States: conditional-funding regulation

The Emergency Medical Treatment and Active Labor Act requires hospitals participating in Medicare to provide an appropriate medical screening examination to any person presenting at an emergency department, and to stabilise any emergency medical condition identified, irrespective of ability to pay or insurance status.³⁰ Enforcement operates through civil monetary penalties and exclusion from the funding programme, and through a private right of action. The American technique is instructive precisely because it does not rely on the criminal law. Compliance is secured by attaching the duty to a funding relationship the institution cannot afford to

²⁶ Compulsory Treatment and Care for Victims of Gunshot Act 2017 (n 1), provision conferring jurisdiction on the High Court of a State.

²⁷ Constitution of the Republic of South Africa 1996, s 27(3).

²⁸ *Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

²⁹ Constitution of Kenya 2010, art 43(2); Health Act 2017 (Kenya), s 7.

³⁰ Emergency Medical Treatment and Active Labor Act, 42 USC s 1395dd.

lose, and by enforcement at the institutional rather than the individual level. Nigeria's National Health Insurance arrangements and its accreditation regime offer an analogous pedestal that has not been used.

12.5 The common lesson

Across all four jurisdictions the duty to provide emergency care is separated from the criminal investigative function. None conditions treatment on notification, and none makes the clinician an agent of law enforcement. Nigeria's Act adopts the same separation in principle, at section 3, but has failed to secure it in practice because the institutional relationship between hospitals and police remains unregulated at the operational level.

XIII. RECOMMENDATIONS

13.1 Express statutory immunity. The Act should be amended to insert a provision in the following terms: "No civil or criminal proceedings shall lie against any hospital, health worker or other person by reason only of the provision of emergency treatment to a victim of gunshot wounds in compliance with this Act or with section 20 of the National Health Act 2014; and no such person shall be arrested or detained in connection with such treatment." The second limb is essential, since the risk practitioners fear is investigative rather than curial.

13.2 A digital notification platform. A national electronic system should be established for the two-hour report, generating an automatic acknowledgment which serves as proof of compliance. This removes the evidential uncertainty and stress that presently attends the reporting duty and creates, for the first time, a dataset on firearm injury presentation.

13.3 An express role for the Medical and Dental Council. The Act should name the Council as a regulatory partner, and the Council should establish an emergency care compliance function and issue the clinical guidance described in Part 10.

13.4 A joint inter-agency protocol. The Federal Ministry of Health, the Council, the Nigeria Police Force, the National Human Rights Commission and the Nigerian Medical Association should adopt a uniform operational protocol governing police attendance at hospitals, the point at which a patient may be interviewed, the certification of fitness by the Chief Medical Director, and the handling of evidentiary material.

13.5 Enforcement of the duties imposed on the police. The Act's obligations on law enforcement should be enforced with the same vigour as those on hospitals, and the Police Service Commission should treat interference with emergency treatment as a disciplinary matter.

13.6 Harmonisation with the National Health Act. The overlapping duties in the 2017 Act and section 20 of the National Health Act should be consolidated, so that a single provision governs refusal of emergency treatment in all cases and the gunshot-specific provisions address only the reporting and police-interface questions peculiar to firearm injury.

13.7 Clarification of the autonomy question. The Act should provide expressly that nothing in it derogates from the right of a competent adult to refuse treatment, while preserving the position in respect of minors and persons lacking capacity.

13.8 Continuous professional training. Training on the Act should be incorporated into the curricula of medical schools and the Police College, and delivered as continuing professional development to clinicians, hospital administrators, police officers and prosecutors.

XIV. LIMITATIONS, FURTHER RESEARCH AND CONCLUSION

This study is doctrinal, and its conclusions concern the coherence and design of the legal framework rather than the measured extent of compliance. Three empirical questions arise from it and merit subsequent investigation: the rate of hospital compliance with the two-hour reporting duty; the incidence of police interference in emergency departments; and the number of prosecutions, if any, brought under the penal provisions of the Act since its commencement. The answer to the third would test directly the enforcement disparity identified in Part 8.3.

The Compulsory Treatment and Care for Victims of Gunshot Act 2017 is best understood not as a health-sector regulation but as an instrument of constitutional implementation, giving effect to the guarantees of life and dignity in sections 33 and 34 of the Constitution and to the right to medical attention in article 16 of the African Charter as domesticated. Its terms are clear and its objective is unimpeachable.

Its ineffectiveness is not attributable to defective drafting of the duty to treat, nor to the reluctance of physicians, whose apprehension of accessory liability is legally unfounded but institutionally rational. It is attributable to the absence of an integrated framework reconciling emergency medical obligations with criminal investigative objectives: an unenforced set of duties on the police, an unnamed regulator, an unaddressed investigative risk for clinicians, and a parallel statutory duty in the National Health Act which the discourse has overlooked.

The remedy lies in harmonisation rather than in further sanction. An express immunity that reaches arrest as well as conviction, a digital reporting

system that makes compliance provable, a named regulator with published clinical guidance, and an inter-agency protocol that fixes the point at which the police may engage with a patient, would together do more to save the lives the Act was passed to save than any increase in the penalties it already contains.