ETHICAL AND LEGAL CHALLENGES IN THE PRACTICE OF ANAESTHESIA

Akudo Nnenne Amanamba*

Abstract

Anesthesiologists bear numerous ethical, legal, and professional responsibilities. Their broad medical practice intersects with the legal system in two key ways. The ethical code sets the boundaries of acceptable conduct through regulation. In contrast, the legal system offers patients and others recourse if these regulations are violated or if an avoidable or preventable injury occurs. This discussion of emerging ethical issues is both timely and essential, given the recognition of anesthesia as a medical specialty. The doctrinal research approach was used to explore the behind-the-scenes roles of Anesthesiologists in relation to ethical and legal issues in their practice, drawing on primary and secondary sources. Our findings suggest that anesthesiology does not pose distinct ethical challenges compared to general medical practice, and causation issues in surgical negligence are not clearly distinguished or detailed in the consent process. We recommend that ethical and legal challenges in anesthesia be addressed proactively and with informed decision-making, prioritising patient safety, legal compliance, and ethical integrity. Continuing education, clear policies, and multidisciplinary collaboration are essential for navigating this complex landscape effectively.

* PhD (Medical Law & Ethics), University of Abuja. LLM (Absu), BL, LLB (Hons) (Absu) MCIArb, (UK). Nurse Anaesthetist/NRNM, UNN Teaching Hospital, Enugu, and QESH (now FMC) Umuahia. Gregory University, Uturu, Abia State. a.amanamba@gregoryuniversityuturu.edu.ng. kudomana@gmail.com
Postal Address: 31 Umuobasi Street, Umuahia, Abia State

Keywords: Anesthesia, Ethics, Legal Challenges, Informed Consent, Patient Safety, Malpractices

1. INTRODUCTION

Anaesthesia represents one of the most transformative advances in the history of medicine, enabling the safe performance of surgical and diagnostic procedures that would otherwise be unbearably painful or physiologically destabilising.[1]. The term anaesthesia literally means "loss of sensation," and modern anaesthetic practice involves the use of pharmacological agents and monitoring techniques to induce controlled unconsciousness, analgesia, muscle relaxation, and suppression of reflex responses[2]. Beyond simply keeping patients unaware during surgery, anaesthesia maintains vital physiological functions, allowing surgical teams to work with precision and care. The development of anaesthesia has therefore been fundamental in shaping modern surgery, obstetrics, emergency medicine, and critical care[3].

Despite its central role, anaesthesia is often misunderstood or undervalued. Patients usually remember little of the procedure, perceiving the work as simple or mechanical. In truth, anaesthesia is complex and demands quick, informed decisions. Anaesthetists assess patient history, evaluate co-existing conditions, plan anaesthesia, administer medications, and monitor and respond to physiological changes throughout.

[1] Ronald D Miller, Miller's Anaesthesia (9th edn, Elsevier 2020) 1
[2] M Butterworth, Morgan and Mikhail's Clinical Anaesthesiology (6th edn, McGraw-Hill 2018) 34.
[3] James Duke, Duke's Anaesthesia Secrets (6th edn, Elsevier 2021) 12.

The unique anaesthetist–patient relationship adds complexity since the patient is often unconscious or sedated, making the anaesthetist fully responsible for their well-being during surgery. Unlike typical doctor–patient interactions, anaesthesia limits the patient's ability to communicate, decide, or express pain or discomfort. This asymmetry highlights the importance of professional responsibility, trust, and clinical judgment.

A critical ethical challenge in anaesthesia concerns informed consent. Although consent is a cornerstone of medical ethics and law, studies show that many patients focus more on the surgery itself and pay insufficient attention to the risks associated with anaesthesia[4]. These risks may include airway obstruction, aspiration, adverse cardiovascular reactions, allergic responses to drugs, or post-operative cognitive complications[5]. Obtaining valid consent, therefore, requires not only providing procedural information but also ensuring that patients understand the potential risks and alternatives in a meaningful way. The difficulty of securing fully informed consent is intensified in emergencies, when time is limited, and in resource-constrained settings where communication may be hindered by language barriers or inadequate pre-operative counselling[6].

Ethical dilemmas also arise where patients lack decision-making capacity. This includes children, unconscious individuals, critically ill patients, and those with cognitive impairments. In such cases, the anaesthetist must rely on substituted consent or act on the principle of best interest, which itself requires careful balancing between medical necessity and respect for

[4] Montgomery v Lanarkshire Health Board [2015] UKSC 11
[5] Duke (n 3) 65
[6] British Medical Association, Consent and Capacity in Clinical Care (BMA 2018) 34

personal autonomy[7]. End-of-life scenarios introduce further dilemmas, particularly when anaesthesia intersects with do-not-resuscitate (DNR) instructions, palliative care, and decisions regarding withdrawal of life-sustaining support[8].

Legal concerns in anaesthesia primarily relate to professional negligence, defined as the failure to exercise reasonable skill and care expected of a qualified practitioner[9]. The legal standard for professional responsibility in anaesthesia is shaped by precedent cases such as *Bolam v Friern Hospital Management Committee***,** which recognises that a practitioner is not negligent if their conduct is consistent with a responsible body of professional practice[10]. However, subsequent rulings, particularly in *Bolitho v City and Hackney Health Authority*, established that professional opinion must also withstand logical scrutiny[11]. This places a dual obligation on anaesthetists: to follow recognised standards and to act logically and reasonably in particular clinical circumstances.

In Nigeria, the practice of anaesthesia is regulated under the Medical and Dental Practitioners Act, with oversight by the Medical and Dental Council of Nigeria (MDCN)[12]. The Nigerian Society of Anaesthetists (NSA) also issues clinical guidelines and professional standards[13]. Nonetheless, the Nigerian healthcare system faces persistent challenges,

[7] Beauchamp and Childress (n 6) 132
[8]J Savulescu, 'End-of-Life Decisions and Medical Ethics' (2014) 23 Journal of Medical Ethics 1
[9] Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.
[10] Bolam (n-12)
[11] Bolitho v City and Hackney HA [1997] UKHL 46.
[12] Medical and Dental Practitioners Act Cap M8 LFN 2004.
[13] Nigerian Society of Anaesthetists, Standards of Practice Guidelines (NSA 2021).

including shortages of trained personnel, inadequate monitoring equipment, limited drug availability, unreliable oxygen supply, and infrastructural deficiencies[14]. These systemic limitations create an environment in which anaesthetists must often make difficult decisions amid resource scarcity, raising ethical issues of justice and fairness in healthcare delivery.

Furthermore, anaesthetists are uniquely at risk of occupational stress and substance misuse due to the ready availability of potent opioids and sedatives in the workplace[15]. Substance dependency among anaesthesia professionals is documented globally and carries serious ethical, clinical, and legal repercussions. It endangers patients, compromises professional judgement, and may result in criminal liability or permanent loss of licensure[16]. Thus, the ethical obligations of self-care, professional conduct, and institutional monitoring become essential elements of safe anaesthesia practice.

Taken together, these considerations demonstrate that the practice of anaesthesia is not simply a technical medical speciality, but one embedded in complex ethical and legal landscapes. The anaesthetist must continuously negotiate between clinical necessity, patient rights, professional responsibility, and legal accountability. Understanding these dilemmas is therefore essential to improving patient safety, strengthening ethical practice, and ensuring a legally resilient healthcare system.

---

[14] . Adesanya AO et al., 'Challenges in Anaesthesia Practice in Nigeria' (2011) 5 Nigerian Journal of Clinical Practice 143

[15] T Bryson and D Silverstein, 'Opioid Misuse Among Anaesthesiologists' (2020) 16 Current Opinion in Anaesthesiology 110.

[16] Medical and Dental Council of Nigeria, Codes of Medical Ethics in Nigeria (MDCN 2008) 88.

2. CONCEPT OF ANAESTHESIA

Anaesthesia is from the Greek word, meaning without pain/insensibility. Anaesthesia enables the painless performance of medical procedures that would otherwise cause severe or intolerable pain to an unanesthetized patient or would otherwise be technically unfeasible.

Anaesthesia is a state of controlled, temporary loss of sensation or awareness that is induced for medical purposes. It may include analgesia (relief from or prevention of pain), paralysis (muscle relaxation), amnesia (loss of memory), and unconsciousness. General anaesthesia suppresses central nervous system activity and results in unconsciousness and total lack of sensation, using either injected or inhaled drugs. A patient under the effects of anaesthetic drugs is referred to as being anaesthetised.

Sedation suppresses the central nervous system to a lesser degree, inhibiting anxiety and the formation of long-term memories without causing unconsciousness. Regional and local anaesthesia blocks the transmission of nerve impulses from a specific part of the body. Depending on the situation, this may be used either on its own (in which case the patient remains fully conscious), or in combination with general anaesthesia or sedation. Drugs can be targeted at peripheral nerves to anaesthetise a specific part of the body, such as numbing a tooth for dental work or using a nerve block to inhibit sensation in an entire limb. Alternatively, epidural and spinal anaesthesia can be performed in the region of the central nervous system itself, suppressing all incoming sensation from nerves supplying the area of the block. In preparing for a medical procedure, the anaesthesiologist selects one or more drugs to

achieve the appropriate type and degree of anaesthesia for the procedure and the patient.

3. EVOLUTION

The concept of anaesthesia has evolved from crude methods of causing unconsciousness via trauma or intoxicants to advanced pharmacological and technological methods based on physiology. Before the nineteenth century, surgery caused full pain, with high death rates from hemorrhage, shock, and infection. The introduction of ether anaesthesia in 1846 and chloroform shortly after revolutionised surgery by enabling precision, reducing suffering, and expanding possibilities.[17].

The evolution of anaesthesia shows advances in pharmacology and a shift from paternalistic care to patient autonomy. Early anaesthetists worked under physicians' authority with little standardisation, but the 20th century saw anaesthesiology become an independent specialty grounded in physiology, pharmacokinetics, airway science, and critical care. These require expert knowledge of patient-specific variables like comorbidities, drug interactions, and physiological reserve. The evolution of anaesthesia has increased legal and ethical scrutiny as anaesthetists' decisions directly impact life functions. The shift from paternalism to rights-based governance forces anaesthetists to justify decisions ethically and legally.

In Nigeria, anaesthesia development has been uneven due to disparities in training, resources, and institutional capacity. While tertiary hospitals

[17] Savulescu J, 'Ethics of pain relief and sedation' (2016) 41 Journal of Medical Ethics 225.

made progress, secondary and rural facilities often lack basic anaesthetic monitoring equipment, raising concerns about justice and patient safety.

We expect not to feel pain during surgery or to remember it, but before the 19th-century discovery of general anaesthesia, surgery was a last resort. It was done while conscious, causing terror, agony, and risk. Few wrote about it to avoid reawakening suppressed memories of torture.

Fanny Burney, a popular English novelist, vividly documented her experience of "terror that surpasses all description" during her mastectomy on September 30, 1811;

> When the dreadful steel was plunged into the breast … I needed no injunctions to restrain my cries. I began a scream that lasted unintermittingly during the whole time of the incision, so excruciating was the agony; I then felt the knife scraping against the breast bone – scraping the breast bone[18].

A few years later, on October 16, 1846, Morton publicly anaesthetised a young male patient at Massachusetts General Hospital during a demonstration where the chief surgeon removed a jaw tumour. The patient appeared unresponsive and unaware, surprising everyone. This marked the start of general anaesthesia, now recognized as one of the most important discoveries.

[18]https\\www.swinburne.edu.au\news\2017.a short history anaesthesia. Accessed on 2nd July 2021.

Ether's remarkable properties sparked the discovery of chloroform, a volatile anaesthetic, spreading quickly from the Atlantic to Britain.[19]

Anaesthesia intersects medicine, ethics, and law. Unlike other clinical fields, it temporarily suspends patient awareness and communication. This places anaesthetists in a position of heightened responsibility, controlling vital functions like respiration, circulation, and consciousness. Since patients under anaesthesia cannot participate in decisions, ethical and legal considerations are central to practice.

Scholars see anaesthesia as highly complex ethically and legally because of patient vulnerability and rapid error consequences. Literature shows dilemmas often involve informed consent, competence, decision-making for incapacitated patients, pain management, end-of-life sedation, and access to safe services. Legally, anaesthetists must adhere to duties of care, maintain competence, uphold confidentiality, ensure proper documentation, and disclose material risks. These are enforced through regulation, case law, licensing, and institutional mechanisms.

In Nigeria, anesthesia began at University College Hospital (UCH) Ibadan and Lagos University Teaching Hospital (LUTH), where expatriates provided medical care, including anesthesia, assisted by trained medical officers, nurses, and dispensers.

The first Nigerian physicians to get the Diploma of Anaesthesia (DA) from the UK in the late 1950s were Dr. Francis Obiakpani at Lagos General Hospital and Dr. (Mrs.) Wuraola Ogunyemi at Lagos Orthopaedic

[19] ibid

Hospital. The first Nigerian to complete the Fellowship in Anaesthesia in the UK was Dr. Philip Nwachukwu[20].

Over the next century, advances in knowledge, technology, and drugs helped anaesthesiologists manage physiological issues caused by anaesthetics and surgery. While patient care remained central, anaesthesia practice expanded to pain management. By the late 19th century, anaesthesiology was widespread, marking one of the first times scientific advances supported medical practice.

In Nigeria, anaesthetic practice is complicated by systemic constraints like inadequate healthcare funding, equipment shortages, workforce migration, and cultural communication barriers.[21]

4. THEORETICAL FOUNDATION

The theoretical framework underpins interpreting ethical and legal dilemmas in anaesthetic practice, which involves decision-making under uncertainty, surrogate judgment, and risk-benefit analysis. Theories from biomedical ethics, jurisprudence, and moral philosophy are essential for rational clinical judgement.

This section covers Principlism, a key ethical framework in anesthetic practice, formulated by Beauchamp and Childress. It rests on four principles: autonomy, beneficence, non-maleficence, and justice. These serve as flexible guides in clinical situations[22].

[20]Odutan. S.A History of Anaesthesia in Nigeria. (University Press. Ibadan. 2001)
[21]ibid
[22] Tom Beauchamp and James Childress, Principles of Biomedical Ethics (8th edn, OUP 2019) 101.

5.0 ETHICAL AND LEGAL CHALLENGES IN THE PRACTICE OF ANAESTHESIA

The anaesthetist's ethical and legal duties are unique because anaesthesia incapacitates the patient, removing their ability to communicate or protect themselves. This temporary unconsciousness shifts the doctor–patient relationship from dialogue and shared decision-making to complete trust in the anaesthetist[23]. This builds a relationship based on fiduciary responsibility, requiring the anaesthetist to act with honesty, diligence, competence, and loyalty to the patient's welfare. Ethically, they must protect the patient's body, dignity, and life while powerless. Legally, this fiduciary duty means deviation from reasonable standards is serious in negligence claims. Anaesthesia's ethical importance also comes from anaesthetists often making decisions without patient input, like choosing techniques, adjusting interventions, and handling unexpected complications. Because the patient cannot object, question, or withdraw consent once unconscious, the burden of justification lies entirely with the practitioner.

Courts see anaesthetic negligence as serious because errors can cause immediate, irreversible harm. Case law shows anaesthetists are liable for mistakes and may also be vicariously liable under doctrines like the 'Captain of the Ship' when they control operating room staff during procedures. This doctrine delineates the limits of control and accountability between the surgical team and the anaesthesia team; however, contemporary legal precedents increasingly regard the

[23] Savulescu J, 'Ethical Challenges in Anaesthesia' (2016) 41 Journal of Medical Ethics 235.

anaesthetist as an autonomous "captain" of their own medical domain, rather than as a subordinate to the surgeon[24].

In Nigeria and similar jurisdictions with frequent structural issues, anaesthetists face situations where ethical obligations surpass institutional capacity, leading to moral distress and legal risks. This tension is a central dilemma in the dissertation.

5.1 Ethical principles in Anaesthetic Practice

Ethical deliberation is essential in anaesthetic practice because it involves placing the patient in vulnerability. Once anaesthesia is administered, the patient is unconscious, unable to communicate, resist, or exercise judgment. The anaesthetist then assumes complete control over the patient, including life support, creating a practice environment where ethical principles serve as ongoing obligations guiding clinical decisions. The most common framework for evaluating ethical dilemmas in anaesthesia is principlism by Beauchamp and Childress, identifying four principles: autonomy, beneficence, non-maleficence, and justice. These principles are culturally neutral and globally accepted, not based on religion or norms. They are complementary but can conflict in practice, requiring anaesthetists to navigate complex moral trade-offs. Unlike surgical consent, which can be obtained beforehand, anaesthesia consent involves explaining risks that are hard for patients to understand. This affects autonomy and raises concerns of paternalism, where practitioners might assume decision-making due to perceived patient misunderstanding.

[24] Souther, Matthew. "The 'Captain of the Ship' Doctrine Gets a New Set of Sails. *Neil & Dymott Attorneys*, https://www.neildymott.com/'captain-ship-doctrine-gets-new-set-sails

5.2 Autonomy and Informed Consent

Autonomy is the patient's right to make healthcare decisions based on adequate information and free from coercion. This is operationalised through informed consent. However, informed consent in anaesthesia is uniquely challenging because

i. Many patients focus their attention on the surgery rather than the anaesthetic procedure.
ii. Anaesthetic risks are complex and hard for patients to understand without medical knowledge. Patients may be anxious and less able to process information before surgery. Emergency cases often limit thorough consent.

The legal standard for informed consent has evolved from the Bolam test, which based on disclosure of what a responsible medical body would share, to the Montgomery standard, demanding that disclosures reflect what a reasonable patient would consider material. This shift emphasizes patient autonomy, making consent a more active ethical duty. Nigeria's consent process in public hospitals often remains informal despite MDCN guidance requiring clear risk explanations before procedures. Factors like time constraints, minimal privacy, language differences, and resource shortages increase the ethical burden on anaesthetists to ensure consent is genuinely meaningful.

5.3 Consent in Patients Lacking Capacity

In cases where patients lack decision-making capacity—like in paediatrics, mental incapacity, unconsciousness, or critical illness—the anaesthetist must rely on substitute consent from a guardian or next of kin,

or act in the patient's best interest. Nigeria's legal framework on substituted consent is fragmented and lacks detailed statutory guidance, unlike the UK's Mental Capacity Act. Nigerian clinicians instead rely on ethical reasoning, professional guidelines, and customary practice. The challenge arises when family decisions oppose medical judgment, especially in cultural or religious contexts where fear of anaesthetic death causes refusal of consent. In such cases, the anaesthetist must balance respecting cultural values and preserving life, often needing an ethics consultation.

5.4. Beneficence

The principle of beneficence requires anaesthetists to act in the patient's best interests by promoting well-being and preventing harm. This guides decisions like choosing the safest anaesthetic based on comorbidities, especially in high-risk patients with heart, lung, or severe anaemia issues. Deciding whether to delay or proceed with surgery is ethically complex; delays may harm, but proceeding risks complications. Beneficence justifies acting without prior consent to prevent harm. However, anaesthetists must explain decisions later and involve surrogates when possible.

5.5 Non-maleficence

Non-maleficence, or "not harm," is key in anaesthesia due to inherent risks of drugs and techniques, like respiratory depression or arrest. Often, harm results from unavoidable risks, making monitoring vital to minimize danger. Poor monitoring standards in Nigerian facilities hinder this, raising ethical concerns about proceeding when safety isn't assured.

5.6 Justice

The principle of justice relates to fairness in healthcare access, treatment, and decision-making. In anaesthesia, justice is challenged when only wealthier patients afford safer environments like private hospitals. Staffing shortages increase workload and fatigue among anaesthetists, raising error risks.

In Nigeria, urban-rural hospital disparities highlight injustice. Anaesthetists often work under conditions that hinder ethical practice, causing distress and moral injury. Justice also involves fair treatment of vulnerable groups like children, pregnant women, the elderly, and critically ill patients who may lack specialised care. In clinical settings, these principles rarely align perfectly. Ethical decision-making in anaesthesia involves negotiation, clinical judgement, communication, empathy, and legal awareness. Mature ethical practice requires following guidelines, reflection, humility, and teamwork. Thus, principlism provides the ethical justification for structured, culturally sensitive consent discussions.

6. LEGAL FRAMEWORK GOVERNING ANAESTHETIC PRACTICE

Nigeria's anaesthesia regulation involves statutory, professional, educational, and institutional controls to ensure safe, competent, and ethical practice. Since anaesthesia affects vital functions and perioperative survival, regulators are vital for safeguarding standards, maintaining trust, and reducing surgical risks.

A combination of statutory provisions, professional ethical codes, judicial precedent, institutional policies, and international best practice standards regulates the practice of anaesthesia. Legal regulation is essential because

anaesthesia involves clinical intervention that may carry significant risks to life and bodily integrity. The anaesthetist, therefore, owes a duty of care to the patient and may incur legal liability where harm results from breach of this duty. The legal framework enables professional accountability, protects patient safety, and reinforces trust in clinical services.

The constitutional framework governing anaesthesia in Nigeria establishes robust protections for patients while imposing clear duties on anaesthetists and healthcare institutions. Rights to life, dignity, liberty, privacy and equality collectively ensure that anaesthesia is administered safely, respectfully and lawfully.[25]. These rights reinforce anaesthetists' professional obligation to uphold the highest standards of care and provide a legal basis for accountability in cases of medical negligence. As Nigerian healthcare continues to evolve, the Constitution remains the supreme instrument guiding ethical and lawful anaesthetic practice, safeguarding patients from the freedom of unwanted medical intervention[26]

6.1 National Health Act 2014

The National Health Act 2014 (NHA) is the most significant contemporary legislation shaping healthcare delivery in Nigeria, and its relevance to the practice of anaesthesia cannot be overstated. Because of its inherent dangers and the complexity of perioperative care, the legal duties outlined in the NHA are crucial for regulating anaesthetists' conduct, protecting patient rights, and ensuring institutional

[25] Ss 33,34,36,42 of the Constitution of the Federal Republic of Nigeria 1999 (as amended),

[26]Medical and dental practitioner's disciplinary tribunal v Okonkwo (2001)7NWLR. (Pt71)1. 206, where the SC linked bodily integrity with personal liberty.

accountability. The Act establishes national standards for health services, mandates informed consent, strengthens confidentiality provisions, reinforces minimum service requirements, and enhances system-wide quality assurance; these provisions collectively influence all stages of anaesthetic practice from pre-operative assessment to intra-operative management and post-operative recovery.

A core contribution of the NHA to anaesthesia practice is its clear protection of patient rights, particularly the right to information. Section 23(1) requires that patients be informed of their diagnosis, treatment options, and associated risks before any procedure is undertaken[27]. For anaesthetists, this statutory mandate forms the legal foundation for the detailed disclosure expected during pre-anaesthetic evaluation. Patients must be informed of the nature of anaesthesia to be used whether general, regional, or sedation and the risks.

The NHA therefore elevates informed consent from an ethical norm to a legal obligation, requiring that anaesthetists ensure understanding and obtain voluntary agreement from the patient or lawful surrogate before administering anaesthesia[28]. In the event of litigation, failure to obtain adequate consent may constitute a breach of both statutory duty and professional standards.

The NHA further emphasises privacy and confidentiality, which are crucial in anaesthetic practice. Anaesthetists regularly handle sensitive information such as pregnancy status, communicable disease status, drug

[27] National Health Act 2014, s 23(1).
[28] National Health Act 2014, s 23(2).

use history, and underlying medical conditions. Section 26 of the Act prohibits the disclosure of such information without lawful justification, except when necessary for treatment or patient safety[29]. This requires anaesthetists to protect patient records, maintain confidentiality even when patients are unconscious, and share information only with authorised healthcare team members.

The confidentiality provision aligns with the ethical standards of the Medical and Dental Council of Nigeria and reinforces legal protections for patient dignity during perioperative care. Another significant aspect of the NHA's relevance to anaesthesia is its establishment of minimum service standards for health facilities. Section 20 of the Act mandates that all healthcare providers uphold essential service quality levels, including appropriate equipment, qualified staff, and functioning safety systems[30]. For anaesthetic practice, this involves ensuring the availability of oxygen supply, operational anaesthetic machines, monitoring devices such as pulse oximeters and capnographs, resuscitation carts, and adequately trained theatre personnel. By establishing institutional responsibilities, the NHA shifts some accountability for adverse anaesthetic outcomes from individual practitioners to health facilities, which are legally required to maintain a safe anaesthesia environment. Hospitals that fail to meet these standards may be held liable for negligence arising from systemic deficiencies.

The Act also emphasises safety and quality assurance. Sections 19 and 20 mandate health establishments to implement continuous quality

[29] ibid
[30] ibid

improvement measures.[31]. These provisions encourage hospitals to adopt global safety practices, such as the WHO Surgical Safety Checklist, and to establish internal clinical governance structures to monitor anaesthetic outcomes.

For anaesthetists, these measures improve the safety landscape within which they operate, reduce avoidable errors, and promote a culture of open reporting and accountability.

Another critical dimension of the Act is its treatment of emergency care. Section 20(3) prohibits healthcare providers from refusing emergency treatment based on inability to pay[32]. This applies directly to emergency anaesthesia in certain situations. Anaesthetists are therefore legally obligated to provide life-saving anaesthesia in emergencies regardless of the patient's financial status. Failure to comply may constitute professional misconduct and a breach of statutory duty.

The NHA also regulates health records, which are central to anaesthetic practice. Section 25 requires healthcare providers to maintain accurate and up-to-date records of patient treatment[33]. In anaesthesia, this includes documentation of pre-operative findings, drug dosages, monitoring charts, intra-operative events, and post-operative instructions. Proper documentation is vital for continuity of care and for defending against allegations of malpractice. The statutory requirement underscores the need for anaesthetic practice to be transparent, accountable, and traceable.

[31] ibid
[32] ibid
[33] ibid

The Act provides a comprehensive legal framework that promotes safe, ethical, and professional anaesthetic practice. The NHA therefore serves not merely as administrative legislation but as a foundational legal instrument that guides anaesthetists in delivering care that respects human dignity and maintains the highest standards of safety. Compliance with the Act is both a professional and legal necessity, and its provisions continue to shape the evolution of anaesthetic practice in Nigeria.

6.2. Medical and Dental Council of Nigeria (MDCN)

At the core of regulation is the Medical and Dental Council of Nigeria (MDCN), the statutory body established under the Medical and Dental Practitioners Act to supervise medical practice nationwide[34]. The MDCN regulates who may lawfully practise anaesthesia by overseeing registration, annual licensing, and maintenance of the medical register. It also enforces the Code of Medical Ethics in Nigeria, which sets professional expectations relating to competence, documentation, informed consent, confidentiality, and patient safety[35]. The MDCN Disciplinary Tribunal investigates cases of misconduct or negligence, including adverse anaesthetic events and perioperative deaths, and imposes sanctions ranging from reprimands to suspension or removal from the register. In this way, the Council provides a statutory framework to ensure accountability and protect the public from unsafe practices.

Another major regulatory influence comes from the National Postgraduate Medical College of Nigeria (NPMCN) and the West African College of

[34] Medical and Dental Practitioners Act (Cap M8 LFN 2004) s 1.
[35] Medical and Dental Council of Nigeria, Code of Medical Ethics in Nigeria (2008) Part B.

Surgeons (WACS), which oversee postgraduate training and specialist certification in anaesthesia. These Colleges regulate training through curriculum development, accreditation of teaching hospitals, supervision of residency programmes, and rigorous multi-stage examinations[36]. The NPMCN Fellowship (FMCA), in particular, is the benchmark qualification required for consultant practice, ensuring that only individuals with verified expertise and advanced clinical competence may function as independent anaesthetists[37]. By mandating continuing professional development, these Colleges also ensure that specialists remain up to date on new techniques, patient safety standards, and emerging scientific evidence.

6.3. Federal Ministry of Health (FMOH)

Regulation is further supported by the Federal Ministry of Health (FMOH), which provides administrative oversight through national health policies, hospital standard operating procedures, infection-control guidelines, and perioperative safety protocols. The Ministry mandates minimum service standards for anaesthetic practice, including requirements for equipment availability, monitoring devices, staff training, and patient documentation[38]. These national standards guide public and private hospitals, ensuring uniformity in service delivery and reducing variations in the quality of anaesthetic care.

6.4 Nigerian Society of Anaesthetists (NSA)

[36] National Postgraduate Medical College of Nigeria Act (Cap N59 LFN 2004) ss 7–12
[37] National Postgraduate Medical College of Nigeria, Part I and Part II Examination Guidelines for Anaesthesia (2020).
[38] Federal Ministry of Health, National Policy on Patient Safety and Quality of Care (2016).

Beyond statutory and administrative regulators, the Nigerian Society of Anaesthetists (NSA) contributes significantly to professional regulation. Although not a statutory body, it functions as the authoritative professional association for anaesthetists in Nigeria. It issues guidelines on airway management, obstetric anaesthesia, critical care, and pain medicine; promotes continuous medical education; and collaborates with international bodies such as the World Federation of Societies of Anaesthesiologists (WFSA)[39]. NSA guidelines frequently inform the "standard of care" applied by courts and disciplinary bodies when evaluating negligence claims.

6.5 Standards Organisation of Nigeria (SON)

Regulation also extends to medical equipment through the Standards Organisation of Nigeria (SON), which certifies medical devices, including anaesthetic machines, ventilators, and monitors, to ensure compliance with safety standards.[40]. Faulty or substandard equipment is a recognised cause of anaesthetic mishaps, and SON's regulatory oversight ensures that devices used in theatres meet required performance and safety specifications.

6.6 Institutional (hospital) Regulation

Finally, regulation is reinforced at the institutional (hospital) level, where medical advisory committees, theatre management committees, drug and therapeutics committees, and clinical audit units develop and enforce internal policies governing perioperative care. These institutional bodies ensure periodic maintenance of equipment, safe storage of controlled

[39] Nigerian Society of Anaesthetists, National Guidelines for Safe Anaesthesia Practice in Nigeria (2019).
[40] Standards Organisation of Nigeria Act (Cap S9 LFN 2004) s 4.

anaesthetic drugs, adherence to WHO Surgical Safety Checklists, and continuous monitoring of patient outcomes through morbidity and mortality meetings[41]. Such internal governance mechanisms serve as the first line of protection against unsafe anaesthetic practice.

Overall, the regulation of anaesthesia in Nigeria is comprehensive and interconnected. Statutory bodies ensure legal accountability; postgraduate colleges guarantee professional competence; administrative regulators safeguard system-wide standards; professional associations update clinical guidelines; and hospitals enforce operational policies. Together, these layers of regulation create a robust framework that supports patient safety, promotes ethical practice, and ensures that skilled and responsible practitioners deliver anaesthesia. Without such a system, the risks associated with anaesthesia would be unacceptably high, compromising both patient trust and the integrity of Nigeria's healthcare system.

7.0 THE ROLE OF THE ANAESTHETIST IN CLINICAL CARE

The practice of anaesthesia is grounded in a rich blend of biomedical science, ethical principles, legal doctrines, and systems-based theories. These theoretical foundations guide the anaesthetist's decisions, ensure patient safety, and provide a structured framework for justifying clinical actions. A theoretical framework, therefore, serves as the intellectual architecture that explains why and how anaesthesia is practised in the manner it is, linking scientific evidence, professional standards, and humanistic values

[41] Federal Ministry of Health, Hospital Services Guidelines (2012).

The role of the anaesthetist has evolved considerably from the early perception of the practitioner as merely an assistant who "puts the patient to sleep." Contemporary literature recognises anaesthetists as perioperative physicians who play central roles across the continuum of surgical and critical care[42]. The anaesthetist's responsibilities begin before surgery, intensify during the operation, and continue into the post-operative period, requiring constant clinical judgement grounded in physiological and pharmacological knowledge.

Before any anaesthetic is administered, the anaesthetist conducts a comprehensive pre-operative assessment. This involves reviewing the patient's medical history, co-existing conditions (such as hypertension, diabetes, asthma, cardiac disease), current medications, allergies, prior anaesthesia experiences, laboratory results, and airway anatomy[43]. The pre-operative phase also involves risk stratification, where patients are classified based on physiological resilience [44].

This assessment not only influences anaesthetic technique but also determines whether it is safe to proceed with surgery at that time. In high-risk cases, the anaesthetist's decision may delay, modify, or even cancel surgery where the anticipated risk outweighs the benefit[45]. This responsibility positions the anaesthetist as a gatekeeper of surgical safety, rather than a passive participant.

---

[42] Butterworth, Mackey and Wasnick, Morgan & Mikhail's Clinical Anaesthesiology (6th edn, McGraw-Hill 2018

[43]Duke, Anaesthesia Secrets (6th edn, Elsevier 2021) 23.

[44] Jameson K, 'Risk assessment in perioperative medicine' (2016) 45 British Journal of Anaesthesia 12

[45] Miller RD, Miller's Anaesthesia (9th edn, Elsevier 2020) 273.

The intra-operative period is the most critical stage of anaesthetic practice. Once anaesthesia has been induced, the anaesthetist becomes the patient's voice, advocate, and life-support system. Because the patient is unconscious, immobile, and unable to respond to harm, the anaesthetist assumes full responsibility for maintaining life-sustaining functions[46].

This high-stakes environment demands constant vigilance. Anaesthetic mishaps tend to progress rapidly and can cause permanent injury or death within minutes if unrecognised[47]. For this reason, anaesthetists are often described as "specialists in catastrophic risk." Their practice requires the ability to interpret subtle physiological changes, anticipate complications before they occur, and intervene decisively.

The period immediately after emerging from anaesthesia can be physiologically unstable. The anaesthetist therefore supervises the patient's transfer to a Post-Anaesthesia Care Unit (PACU) or intensive care environment[48]. Pain management is a significant ethical issue. Undertreated pain diminishes the quality of recovery and violates beneficence, while over-sedation increases the risk of respiratory collapse[49]. Thus, the anaesthetist must constantly balance comfort and safety[50].

[46] ibid
[47] Pandit JJ, 'Patient safety in anaesthetic practice' (2014) 72 Anaesthesia 93.
[48] ibid
[49] Gawande A, Complications (Picador 2002) 144
[50] Savulescu J, 'Ethics of pain relief and sedation' (2016) 41 Journal of Medical Ethics 225.

Anaesthetists therefore operate at the convergence of scientific precision, ethical responsibility, and legal scrutiny, making their practice one of the most demanding areas of modern medicine.

7.1 Duty of Care in Anaesthetic Practice

Duty of care refers to the legal obligation imposed on medical practitioners to provide treatment that meets the standard of a reasonably competent practitioner under similar circumstances[51]. In anaesthesia, the duty of care begins from the moment the anaesthetist undertakes preoperative assessment and continues through intraoperative monitoring and postoperative recovery care[52].

This duty is heightened because the patient under anaesthesia is rendered unconscious or cognitively impaired, leaving their life functions entirely dependent on the anaesthetist. The law recognises this vulnerability and requires vigilant monitoring of physiological parameters, including oxygen saturation, ventilation, blood pressure, temperature, and neuromuscular function. Courts have repeatedly held that failure to observe a patient's vital signs constitutes breach of duty[53]. In Nigeria, the general legal standard for the duty of care in the healthcare setting is derived from the common law of negligence and is shaped by judicial interpretation.

7.2 The Standard of Care

[51] Medical and Dental Council of Nigeria, Code of Medical Ethics in Nigeria (MDCN 2008) 78.
[52] ibid
[53] PM.Nnamani v Nnaji &Another (2011) 46. NWLR(Pt.1269). (CA)

The classical test for medical negligence is the Bolam Test, which holds that a practitioner is not negligent if their conduct is in accordance with a responsible body of professional medical opinion[54]. This principle, known as the Bolam Test, granted broad discretion to medical professionals. The plaintiff, John Bolam, was a patient at Friern Hospital, where he was treated for depression. As part of his treatment, he was given electroconvulsive therapy (ECT). However, he was not given any relaxant drugs to prevent injury during the treatment. As a result, he suffered a fractured pelvis. The plaintiff sued the hospital and its staff, alleging that they had been negligent in failing to provide him with relaxant drugs during the ECT treatment.
The court held that the defendants had not been negligent. The judge, McNair J, stated that a doctor is not negligent if he acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

This test has been widely applied in medical negligence cases, and it remains a key principle in determining the standard of care owed by healthcare professionals to their patients. However, the Bolam test has been the subject of much debate and criticism over the years. Some have argued that it provides too much defence to the medical profession and allows doctors to set their own standards of care, which may perpetuate a culture of self-regulation within the medical profession and that the Bolam test lacks clarity. The test requires that a doctor's actions be in accordance with a practice accepted as proper by a responsible body of medical men. However, it is not always clear what constitutes a "responsible body of medical men." The Bolam test has also been

[54] Bolam v Friern hospital Management Committee (1957)2 ALL ER 118

criticised for providing inadequate protection for patients. By allowing doctors to set their own standards of care, the test may not adequately protect patients who are harmed by substandard care[55].

However, the Bolam test remains a vital principle in medical negligence law, as it recognises that healthcare professionals have a high level of expertise and independence in their practice. In recent years, the courts have modified the Bolam test to require that the accepted practice be both logical and reasonable in *Bolitho* case, the House of Lords stated that the Bolam test must be adjusted to include the requirement that the accepted practice is logical and reasonable. The court ruled that a doctor's actions must not only align with a practice considered proper by a responsible medical body but also must be logical and reasonable[56]. Similarly, in *Montgomery v Lanarkshire Health Board*[57], the Supreme Court declared that the Bolam test should be amended to require doctors to provide patients with enough information to enable them to make informed decisions about their care. Nevertheless, this approach risked protecting medical standards by professional opinion, even when questionable. This means that anaesthetist decisions must not only follow established practice but also be rational, evidence-based, and defensible.

The combined Bolam-Bolitho standard now requires that:

a) The anaesthetist's actions correspond to accepted professional practice; and

[55] Aiyede, E.O.A. The Bolam Principle; A Nigerian Perspective. In A.A. Adebowale (Ed.) Essays in Medical Law . 2012.(pp.123-145) University Press Ibadan.
[56] Bolitho v City and Hackney Health Authority. (1997) 4. ALL ER. 771
[57] (2010) CSOH. 104…4.121.

b) That practice must be logical, safe, and aligned with contemporary scientific knowledge.[11]

Nigerian courts frequently reference these standards in medical negligence cases. [12]

8. CONCLUSION

Anaesthesia is a groundbreaking medical innovation that has revolutionised surgical and diagnostic procedures. Nonetheless, it introduces complexities that raise significant ethical and legal considerations. The practice demands a careful balance between medical necessity, patient autonomy, and professional responsibility. As the field evolves, it is crucial to address new challenges and complexities to ensure patients receive safe, high-quality care.

9. RECOMMENDATIONS

Anaesthesia is a vital part of modern medicine, and its safe application is crucial for patient care. To achieve this, we recommend enhancing patient education, strengthening consent procedures, and increasing professional accountability. Moving forward, it is essential to prioritise patient safety, promote professional excellence, and address the systemic challenges that obstruct anaesthesia practice. By working together, we can ensure that anaesthesia remains a fundamental element of medical care, providing patients with safe, effective, and compassionate treatment.