UNIVERSITY OF EDUCATION, WINNEBA

HUMAN RIGHTS IMPLICATIONS OF MEDICAL NEGLIGENCE IN CENTRAL AND GREATER ACCRA REGIONS OF GHANA

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HUMAN RIGHTS IMPLICATIONS OF MEDICAL NEGLIGENCE IN CENTRAL AND GREATER ACCRA REGIONS IN GHANA

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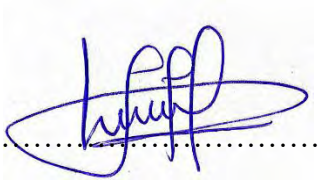
DECLARATION

STUDENT'S DECLARATION

I, Mercy Larbi, declare that this thesis, with the exception of quotations and references contained in published works, which have been duly identified and acknowledged, is entirely my own original work, and has not been submitted, either in part or whole, for another degree elsewhere.

SIGNATURE:  .....

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SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the School of Graduate Studies, University of Education, Winneba.

Dr. Seth Tweneboah (Supervisor)

Signature: .....

Date: .....

DEDICATION

This work is dedicated to my family.

ACKNOWLEDGEMENTS

I am immensely grateful to my supervisor, Dr. Seth Tweneboah, for his patience, selfless dedication, guidance, meticulous critique and suggestions in helping to shape this work to a successful completion. All I ask for is the blessings and favour of the Almighty God on him and his entire family.

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ABSTRACT

Drawing on the experiences of victims of medical negligence in Ghana's Greater Accra and Central Regions, this study sought to explore the human rights implications of medical negligence, exploring victims' self-narrated experiences of medical negligence. An interpretive research paradigm and a qualitative research approach were employed in the study. The study adopted case study design, and snowballing sampling technique to sample ten participants from both regions. One-on-one interview technique was employed to collect primary data. Data collected were analyzed thematically. The study found that participants have limited knowledge of their rights as enshrined in the Ghana Patients' Charter. Surgical negligence, prescription and medication administration errors, and misdiagnosis errors were found to be common medical negligence episodes. The willingness or otherwise to pursue legal action against healthcare practitioners was influenced by fear of victimization, time and energy required, and sociocultural value of non-litigation. The study recommends that there is the need for the Commission on Human Rights and Administrative Justice (CHRAJ), National Commission for Civic Education (NCCE) and Ghana Health Service (GHS) to embark on intensive and sustainable public education and sensitization on the Patient Charter. It further recommended that human rights courses be integrated into health practitioners training curriculum and be made compulsory for all individuals willing to take up careers in healthcare services.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter presents an introduction to the entire work under the following sub-themes: background to the study; research problem; purpose of the study; objectives of the study; research questions; significance, scope of the study, operational definition of terms and organization of the study.

1.1 Background to the Study

This study examines the manner in which medical negligence constitutes a significant human rights challenge in society. It is worthy of note that healthcare providers in general have a professional, legal, and moral duty to their patients. Professionally, healthcare providers have a responsibility to provide medical help in order to save patients' lives. Legally and morally, health professionals are duty-bound to constantly uphold the highest professional standards and to have a responsibility to protect human life. However, these legal, professional, and moral duties are oftentimes consciously or unconsciously not upheld in the course of medical treatment. In most cases, the neglect of this core mandate has led to diverse forms of abuse and human rights violations (Akter, 2015).

In this study, therefore, I seek to draw on the lived experiences of victims of medical negligence in Ghana's Greater Accra and Central regions, to explore the human rights implications of medical negligence, interrogating victims' awareness of the Ghana Patient Charter, the common medical negligence experiences as well as the legal and human rights implications of medical negligence. It is important to note that, medical negligence is a worrying breach of one's right to health by a professional organization that is supposed to

protect one's health rights when an emergency occurs. Many developed and emerging economies have recently focused their attention and discussion on medical negligence, and as a result, many of them have adopted and established distinct Acts and courts to improve healthcare laws (Akter, 2015). For instance, in Ghana, patients' rights and responsibilities have been codified into a legal document known as the Patient's Charter. The Public Health Act, 2012 (Act 851) in particular, has listed the patient's charter as the sixth schedule.

The World Medical Association Declaration of Geneva 1948, requires a member of the medical profession to formally vow to proclaim that the health of the patient will be a doctor's first consideration. Notwithstanding the many efforts to deal with episodes of medical negligence, it continues to be a major healthcare challenge globally. What makes it more worrying is the unwillingness of many victims to report the incidence of medical negligence.

The Ghana Health Service Patients Charter lays forth the patient's rights and responsibilities. However, according to a study by Oti et al (2016), there is a growing concern in Ghana about patients' clinical experiences and healthcare in general. Their study focused on vulnerability from the patient's point of view. They described vulnerability to include bodily and/or mental harm, injury, or harm, being powerless or weak in self-defense, and being open to assault. Thus, patient's vulnerability refers to a patient's inability to maintain control over their living conditions or to defend themselves from hazards or threats to their integrity (Obu, 2021). Irurita and Williams (2001) define integrity in this sense as having control over one's life (situation), being able to defend oneself, keeping dignity as a human being, remaining healthy, intact, undiminished (physically and emotionally); and be in a good state as possible. Using this definition, a

considerable part of Ghana's patient population might be said to be vulnerable, as many ailments render the patient unable to fully control himself or herself, including the inability to make autonomous decisions. This is evidenced in some reported and unreported cases of medical negligence in Ghana (Obu, 2021). Obu (2021) notes that there are a number of factors that yield to medical negligence. Power imbalance between the doctor and patient has been identified as a key reason for this situation.

The doctor possesses knowledge and skills as opposed to the patient and seeks to put to use for his or her own benefit. This observation corroborates with Oti et al. (2016) who studied a total of 170 patients and found that 84.7% (144) had no idea about the Patients Right Charter from Ghana Health Service. 75% (128), did not know or has not heard of informed patient consent. Of those who knew of the charter, 85% (37) have ever stayed in a developed country; 60% (102) did not know of their diagnosis; 79% (134) said the doctor only told them they were due for surgery and asked them to either sign or thumbprint the consent document without giving them treatment options or possible complications; 58% (98) wanted to be part of the decision process in their treatment. Further 42% (76) think that doctors know the best, so should choose the treatment for them. These findings further strengthen the argument that there exists a power imbalance or disequilibrium between the doctor and the patient. The human rights violations that occur often results from such situations. It is against this background that this study is motivated to explore victims' experiences of medical negligence in Ghana by examining the human rights implications. The study uses the Central and Greater Accra Regions as reference points.

1.2 Statement of the Problem

In general, healthcare providers have a professional, legal, and moral obligation to their patients. Health practitioners have a professional obligation to give medical assistance in order to save patients' lives. Health professionals must always respect the highest professional standards, both legally and morally, and remember that they have a responsibility to preserve human life. For example, the Patient's Charter of Ghana touches on the following issues: the right to high-quality, easily accessible, equitable, and all-encompassing healthcare within the limits of the nation's resources, respect for the patient as an individual a right to decision-making regarding his or her healthcare strategies, rights to protection from discrimination based on race, gender, age, the color of skin, religion, and various illnesses and disabilities the patient's or client's obligations to promote, prevent, and treat simple ailments in order to maintain their own and the community's safety. It is expected of every healthcare professional to support and uphold the responsibilities and rights of patients, clients, and families. However, existing studies (Oti et al., 2016; Obu, 2021) suggest that many patients in Ghana do not know about this Charter and what it entails. This points to a serious disregard for patients' rights to health which consequently manifests itself into medical negligence. However, when it comes to studying the topic of medical negligence, there is a startling scarcity of data. To be sure, there have been some insightful works that provide insights into legal viewpoints on medical malpractice in Ghana (Oti et al., 2016; Obu, 2021). Significant gaps continue to exist when it comes to the exact human rights implications of medical negligence. As a result, the current study seeks to conduct an examination into the problem of medical negligence to provide a better understanding of the situation from the victims' point of view.

1.3 Purpose of the Study

The purpose of the study is to explore the human rights implications of the experiences of victims of medical negligence in Ghana with specific reference to the Central and Greater Accra Regions.

1.4 Objectives of the Study

The study was guided by three key research objectives, namely to:

(i) examine patients' level of knowledge or awareness of the Ghana's Patient's Charter

(ii) explore the experiences of victims of medical negligence in the Central and Greater Accra Regions of Ghana.

(iii) examine challenges victims face in seeking redress of medical negligence in the Central and Greater Accra Regions of Ghana.

(iv) analyze human rights implications of medical negligence in the Central and Greater Accra Regions of Ghana.

1.5 Research Questions

The following research questions guided the study:

(i) What have been the level of patients' knowledge about the Ghana's Patient's Charter?

(ii) What are the experiences of medical negligence victims in Ghana's Central and Greater Accra Regions?

(iii) What obstacles confront victims of medical negligence in seeking remedies for medical negligence?

(iv) What are the human rights implications of medical negligence in the Central and Greater Accra Regions of Ghana?

1.6 Significance of the Study

This study is significant in three key ways: 1) gaps in knowledge, 2) methodological approach, and 3) policy implication. In terms of its contribution to knowledge, the study sought to extend the body of knowledge already in existence on medical negligence by looking at the human rights implications of medical negligence largely ignored in existing literature. Scholars such as Oti et al. (2016) and Obu (2021) have done some insightful work that leads to legal viewpoints on medical malpractice in Ghana. For example, Oti et al (2016) investigated "Informed Consent under the Ghana Health Service Patients Charter: Practice and Awareness." These studies largely focus on the legal implication of medical negligence. The exact human rights implication of medical negligence has not been systematically analyzed. The current study, therefore, seeks to take up this challenge by become the first systematic study to fill in this worrying lacuna.

In terms of methodology, existing studies have largely adopted a content analysis methodology to examine the various legal instruments and policies put in place to protect patients. For instance, Obu (2021) investigated "Researching into Medical Law and the Surge in Medical Negligence in Ghana: Proposition for a Specialized Healthcare Court to Deal with Such Cases employing content analysis. In line with current approaches to human rights research and reportage as outlined in the *Human Rights Monitoring Field Mission Manual* (2008), the current study makes a good contribution in terms of methodology by using a victim-focused qualitative research approach and a descriptive case study design to give voice to the direct concerns of victims of medical negligence. The third significance of the study is that it aims to serve as a guide for Ghana's

developmental policy formulation on issues related to healthcare delivery. According to Target 4.7 of the UN Sustainable Development Goal, education is the means through which states can achieve sustainable development and global citizenship. As a result, it projected that by 2030, state must ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development. By specifically paying attention to medical negligence as an essential human rights issue, the study hopes to participate in the larger academic and political discourse on achieving sustainable development in Ghana especially as relates to matters of healthcare delivery.

1.7 Scope of the Study

The study is limited to the Central and Greater Accra Regions of Ghana. The study fundamentally explores the experiences of medical negligence victims.

1.8 Operational Definition of Terms

Medicinal Negligence: This term is used in this study to mean a legal claim that arises when a medical or healthcare professional violates professional standards by a careless act or omission, resulting in patient injury.

Medical Negligence Victims: This phrase is used in this study to describe the actual victims of medical malpractice and their family members or relatives as well as bystanders or witnesses.

Human Rights: Human Rights are conceptualized in the current study to mean claims we have by virtue of the fact that we are human beings rather than citizens of a country.

Human Rights Violation and, or Abuse: These terms are used concurrently or interchangeably in this study to mean the intentional act of causing losses, harm, or hurt in the aspect of human rights.

1.9 Organization of the Study

The study is organized into five (5) chapters. The first chapter provides an introduction to the entire work under the following sub-themes: Background to the study; the research problem; the purpose of the study; the objectives of the study; research questions; the significance of the study and the organization of the study. Chapter two concentrated on a review of theories for a better understanding of medical negligence which led to an appraisal of relevant empirical literature on medical negligence. Chapter three presents the methodology under the following sub-themes: Research paradigm; research approach; study design; population; sampling design (sample size and distribution and sampling techniques); data sources and instruments; data management and analyses; ethical considerations and safety protocols adopted in the study. Chapter four discusses the results and findings of the study. Chapter five, which further presents the summary, conclusion, and recommendations of the study.

CHAPTER TWO

REVIEW OF RELEVANT LITERATURE

2.0 Introduction

This chapter reviews relevant extant literature on medical negligence, a phenomenon that threatens human life, and the enjoyment of the right to quality healthcare and undermines the fundamental human rights of its victims. The chapter is divided into two main parts: the first deals with a theoretical review that employs the subjective and objective theories of negligence to give a vivid account and an interpretation of how medical negligence emanates in contemporary Ghana. The second centers on an empirical review of relevant related literature which further elucidates the phenomenon of medical negligence under the following sub-themes: The Concept of Medical Malpractice, Ghanaian Laws and Medical Negligence, Cases of Medical Negligence in Ghana, Medical Negligence and Human Rights and Reporting Cases of Medical Negligence in Ghana.

2.1 Theoretical Framework

2.1.1 Subjective Theory of Negligence

This study employed two key theories – the subjective and objective theories of negligence as its framework. Largely attributed to John Salmond, an eminent legal elite, the subjective theory of negligence was propounded in 1907 as part of Salmond's larger project of interpreting the law of torts (Salmond, 1961). It is a theory particularly used to account for the law of torts in society and the resultant consequences to the perpetrator of negligence. Central to Salmond's subjective theory of negligence is that negligence is an irresponsible carelessness. Although negligence is not synonymous with thoughtlessness or inadvertence, it is fundamentally an attitude of indifference. The theory suggests that

negligence requires a mental attitude of disproportionate carelessness in parts of one's behaviour.

Following Salmond, scholars have interrogated the notion of negligence in analyzing social issues. According to Austin (1961), the core or radical concept in the theory of negligence is the lack of advertence, which one's responsibility would naturally indicate. Austin provides us with an understanding that negligence is the outcome of carelessness or failing to consider the nature and repercussions of one's wrongdoing. Negligent conduct is the exact opposite of a deliberate act in this context. Austin's (1961) assertion that negligence might be unintentional or intentional has received criticism. One may inflict injury without necessarily meaning to inflict injury, such as by carelessness with regard to the ramifications of harmful conduct or through an erroneous belief that bad outcomes would not occur, thereby suggesting an element of unintentional carelessness. This is the most typical example of negligence and is what Austin meant. However, there is another type of negligence in which there is no carelessness or error. For example, if a person drives a car faster in a crowded street, he may be fully aware of the risk involved and the danger to which others are exposed, but if an accident occurs to someone, it cannot be stated that he intended it; instead, he may only be guilty of negligent homicide rather than murder.

According to Salmond (1961), negligence is the mental attitude of undue carelessness for one's actions and their consequences. For Salmond (1961), the core of negligence is not inadvertence, which may or may not be the result of carelessness, but carelessness, which may or may not result in advertence. Acts are commonly divided into two categories: intentional and negligent (Salmond, 1961). An intentional act is one whose results are

anticipated and intended by the perpetrator. Forbearance refers to the act of not doing something on purpose. As a result, forbearance is a deliberate negative behaviour. Omission, on the other hand, is not doing something without exerting mental effort. As a result, the omission is an inadvertent negative act, whereas forbearance is also the result of intent, and omission is the result of negligence. If the purpose is a state of mind, then so is the absence of intention or negligence.

The subjective theory argues that in certain cases, determining whether a person was negligent will be influenced by his or her mental state. In criminal law, there is a stark distinction between purposefully inflicting injury and negligently causing harm, and in determining whether the accused is guilty of either, one must consider the knowledge, intentions, motives, and so on. Examples of apparent negligence may turn out to be cases of improper purpose after an analysis of the party's state of mind. For instance, a trap door can be left unbolted so that an opponent can fall through it and die. If a parent fails to provide treatment for his sick child, he may be charged with deliberate murder rather than just negligence. In none of these circumstances can we differentiate between purposeful and negligent conduct without seeing into the offender's thoughts and examining his subjective attitude toward his actions and their consequences. The two types of offenses are indistinguishable from an external and subjective standpoint.

2.1.2 Objective Theory of Negligence

Largely credited to the work of Federick Pollock (n.d), an English jurist in his *History of English Law*, the theory of negligence is a theory particularly used to account for the law of torts in society and the resultant consequences to the perpetrator of negligence. The

theory holds that negligence is an objective fact and it is not based on the state of mind as described by Salmond (1961). Federick Pollock insisted that negligence is a particular kind of conduct. It is a breach of duty to care and by saying to care means to take all possible precautions against those actions which can result in injury or any harm to others. According to some jurists, negligence is a type of behaviour rather than a state of mind. According to this viewpoint, negligence results from a failure to take necessary measures. According to Clark and Lindsell (1906), negligence is the failure to exercise the care that a person is legally required to exercise under the circumstances. To them, negligence is the opposite of diligence, and no one defines diligence as a state of mind.

According to objective theory, negligence is an objective fact rather than a subjective one. It is not a certain state of mind or type of vicarious liability, but rather a specific type of behaviour. Negligence is a violation of the duty of care. To be cautious implies taking measures against the negative consequences of one's actions. Negligence is defined as engaging in an activity that a reasonably prudent person would avoid (Clark and Lindsell, 1906). Driving at night without a light is negligent because carrying a light is a cautious man's act. Taking care is thus no longer a mental attitude or state of mind. The objective theory is strongly supported by tort law, which states unequivocally that negligence is defined as a failure to meet the objective standard of reasonable behaviour. However, Salmond (1961) was critical of the objective theory for the following reasons: Incomplete analysis results in complete identification of negligence with failing to take care; Failure to exercise caution is not usually the result of carelessness; Failure to take measures may be unintentional or intentional; It is impossible to determine if a man's lack of care is negligent, purposeful, or unintentional based just on his actions; Only by examining the

mental attitude of the man who committed the negligent act can the negligent act be identified.

Glanville (1981) tries to reconcile both theories by claiming that the term negligence has two meanings and that each of the two theories represents one of them. On the one hand, there is the intention, and on the other, there is the unavoidable accident. As opposed to intent, negligence is subjective (a state of mind). For example, poison may be left unlabeled in the hope that someone may drink it and die as a result. Without peering into the offender's thoughts, it is difficult to determine if the conduct was purposeful or negligent. It's possible that leaving the poison in such a condition was an accident. In contrast to an unavoidable accident, neglect is a specific form of behaviour. If the question is whether the defendant produced the harm without his fault or through his inadvertent fault, the only way to answer it is to look at whether his conduct met the standard of a reasonable man. As a result, it is possible to assert that subjective and objective theories work in different fact contexts and that it would be incorrect to assume any inherent conflict between them.

The Subjective and Objective Theories of Negligence are appropriate fit for the current study because they help us frame how incidents of medical negligence must be interrogated, the manner in which such issues are usually subjected to the question of whether the perpetrator (health worker) fully, knowingly and consciously produced the harm. By deploying these twin theories, there is the advantage of, later in the discussion, better understanding the human rights implications of the experiences of victims of medical negligence in Ghana with specific reference to the Central and Greater Accra regions.

2.2 Empirical Review

2.2.1 Defining Negligence

In its most basic sense, negligence is understood as the failure to take proper care over something. It the failure to meet the standard of behaviour that guides a particular field. From the legal point of view, according to Simons (1999), negligence has understood as the failure to meet a standard of behaviour established to protect society against unreasonable risk. Thus, reasonability becomes an essential determining factor here. Academic studies have noted that this meaning of negligence has great importance in both morality and law (Simons, 1999, p.54). Thus, the act of negligence is a state of executing an activity wrongly or failing to execute an activity at its rightful time which causes harm to others.

According to Simons (1999, p.55), there are three conceptions of negligence which are related to morality and law. First, there is the notion of unjustifiable risk whereby a negligent act results in an unreasonable or unjustifiable risk of future harm. The second conception bothers on evaluation according to a "reasonable person" criterion. Here, according to Simons, a negligent act, belief, or attitude occurs because a reasonable actor refuses to perform; it is a belief or attitude that a reasonable person would not harbour. The third conception emphasizes culpable or unreasonable inadvertence whereby the actor, while unconscious or unaware of a risk, should have been in the known. Simon's notes despite the conceptual differences, these three conceptions interrelated and intersect (Simons, 1999, p.55).

A negligent act generates unreasonable risks, regardless of whether a "reasonable person" would act otherwise. According to a so-called "subjective" test of negligence, you are not

negligent if you do your best given your particular capabilities, although you may still create unjustified risks (Simons, 1999).

A reasonable person test, on the other hand, may be used to evaluate options with almost predictable outcomes. For example, in self-defense, the primary legal standard effectively asks whether a reasonable person in the defendant's place would use the purposeful force that the defendant used (Simons, 1999).

The most significant sense of negligence is arguably the first conception, the unjustified creation of, and failure to take a precaution against future risk of harm. The second conception, the "reasonable person," is basically a legal conception, reflecting specific pragmatic and institutional aspects unique to law. The third notion, "inadvertence," is not without significance, but the issues it raises are very broad in scope (Simons, 1999).

In conclusion, the negligence concept is as follows: Lack of justification is part of the conventional definition of negligence. This aspect generates an intriguing asymmetry between negligence and the other types of misconduct to which it is commonly related. Negligence is a composite term in which a careless person both generates and is unjustified in creating harm.

For example, an intentional killer aims to cause death, and a knowing killer (as commonly described) believes that his actions will almost certainly result in death; but, in either instance, the actor may be justified (for example, because he is defending himself against a culpable aggressor). Lack of reason is inherent in the concept of negligence, but it is not inherent in the concept of willfully or knowingly causing harm.

2.2.2 Professional Negligence

Professional negligence is a breach of the professional's duty of care to their clients. The duty of care is a common law system in which the client expects a certain level of professionalism and professional standards. For example, medical malpractice is the most popular word for medical professional negligence (Ahsan, 2013). In this case, the patient expects the doctor and his subordinates to follow standards that will protect patients under his or her care from unnecessary injury and discomfort. We frequently hear about people dying as a result of medical malpractice. An angry mob would storm the hospital and destroy its property. The media, as well as the police, will be present. The worried doctor would routinely reject any liability, while the family members would insist that the doctor was careless (Ahsan, 2013).

The better solution according to Ahsan (2013) is to consult an expert with all of the information and reports to identify the true cause of the death. If there is prima facie evidence of medical malpractice, you may want to consider suing the doctor and the hospital administration. Negligence on the part of the doctor while performing his professional duties is malpractice, which violates the patient's duty of care and will result in legal sanctions.

2.2.3 The Tort Law and Medical Negligence

Tort is defined by Sir Johns Salmond (1907) as a civil wrong for which the remedy is an action for damages and which is not solely a breach of contract, breach of trust, or any merely equitable obligation. The core notion of tort law is negligence, which consists of: a legal requirement to exercise reasonable care; a breach of the duty, and subsequent damages. The scope and dimension of a health professional's liability for acts of medical

negligence are extremely broad, and any person who has been hurt may file a claim for damages in court.

The forum for submitting the action will be determined by the number of damages claimed, which will range from sub-ordinate courts to the Supreme Court. It is the doctor's responsibility to provide medical support in order to save patients' lives. After providing the required medical assistance, the doctors may follow the legal procedure (Pandit &Pandit, 2009).

It is instructive to indicate that there is a positive association between medical negligence and the law of tort. To be sure, the medical profession, indeed, is seen as noble since it facilitates in the longevity of life. For many, the belief is that life is a gift from God. In this sense, a doctor whose aims is to sustain life is said to act in loco Deus (in place of God) playing in God's plan because he stands ready to carry out His command (Pandit &Pandit, 2009). A patient typically seeks out a doctor or facility based on the doctor's reputation. A patient's expectations are twofold: doctors and hospitals are expected to offer medical treatment with all of the knowledge and expertise at their disposal, and they are also required not to hurt the patient in any way due to negligence, carelessness, or recklessness on the part of their staff (Pandit &Pandit, 2009).

Pandit and Pandit (2009) suggest that though a doctor may not always be able to save his patient's life, they are expected to apply their specialized knowledge and ability in the most appropriate manner while keeping the patient who has entrusted his or her life to the doctor. As a result, it is required that a doctor conducts the appropriate examination or collects a report from the patient. Furthermore, unless it is an emergency, doctors are required to ask

for the patient's informed consent before beginning any significant treatment, surgical procedure, or even invasive examination (Pandit &Pandit, 2009).

Failure to discharge these duties by a doctor or hospital is essentially a tortious liability. A tort is a civil wrong (right in rem) as opposed to a contractual obligation (right in personam) - a breach that invites judicial intervention in the form of monetary compensation. As a result, a patient's entitlement to medical care from doctors and hospitals is fundamentally a human right. To some extent, the relationship takes the form of a contract due to informed consent, payment of bills, and performance of surgery/providing treatment, etc., while keeping fundamental tort elements (Pandit &Pandit 2009).

2.4.2 Defensive Medicine

Defensive medicine, also known in the literature as defensive medical decision-making entails medical procedures intended to forestall potential malpractice claims in the future (MedicineNet.com, 2021; Studdert et al., 2005). In defensive medicine, actions are conducted more for the sake of limiting responsibility than for the benefit of the patient (Studdert et al., 2005).

In order to lessen their exposure to malpractice litigation, doctors may decide to order tests, treatments, or visits, or elect to keep clear of high-risk patients or operations. One of the least desirable impacts of the increase in medical lawsuits is defensive medicine. There is evidence in the literature that the price of healthcare rises due to defensive medicine, which also puts patients in undue danger (Studdert et al., 2005).

According to Kapp et al. (2016), defensive medicine is "clinical practice that is driven by the physician's perception of legal self-interests." Depending on the circumstance,

defensive medicine may be beneficial or harmful. The former, for instance, entails carrying out needless diagnostic tests and invasive procedures, prescribing needless treatment, and requiring needless hospitalization. The latter is refraining from risky operations on patients who would have benefited from them, so disqualifying individuals from receiving treatment and being admitted to the hospital. Both of these behaviors are becoming more and more standard medical practice, which raises healthcare costs and occasionally degrades the standard of care (Kapp et al., 2016). For instance, unnecessarily invasive diagnostic tests expose the patient to additional risks and expenses. In research by Studdert et al. (2005) of 800 doctors in Pennsylvania to ascertain the prevalence of defensive medicine, it was discovered that 92% of doctors ordered imaging tests and diagnostic procedures for assurance, whereas 42% avoided high-risk treatments and patients with complications.

In research by Gallup and Jackson Healthcare (2010), private sector physicians admitted to using defensive medicine at rates of 73% and 92%, respectively, which was higher than the 48% rate for public sector doctors. The research cited above indicates how common defensive medicine is as a result of litigation anxiety. According to Rodriguez, et al. (2007), malpractice lawsuits affected 50% of the medical professionals working in emergency rooms in California between 2001 and 2005. Similar findings were found in an earlier study conducted by Hiyama et al. (2006) in Japan among 131 gastroenterologists; Anupam and Seabury (2016) study revealed that between 60 and 90 percent of American doctors practice defensive medicine just to limit their exposure to legal risk. The U.S. has incurred costs of up to $50 billion yearly, although this certainly understates the severity of the issue (Anupam & Seabury, 2016). Their study further found that doctors who spend more money

and resources performing tests and treatments for patients are less likely to be accused of malpractice. Drawing on the aforementioned information, the current study seeks to frame its discussion within the context of the effectiveness of defensive medicine in Ghana.

2.3 Human Rights, Medical Negligence and Healthcare in Ghana

This section of the study reviews extant materials related to healthcare in Ghana and its human rights consequences. The review focused on both academic scholarly studies as well as the media reportage of some of the episodes of medical negligence. It aims to track the patterns and prevalence of medical negligence in Ghana.

Over the last two decades, practically every country in the world has become a party to at least one human rights treaty or equivalent international instrument that addresses health and healthcare-related rights (WHO, 2017). The recognition of healthcare as a human right empowers rights holders to hold duty bearers accountable. According to Owusu-Dapaah (2015), many nations have made headway in incorporating their international human rights duties concerning health into their domestic legal and policy frameworks. These human rights requirements have been elevated in certain countries, including Ghana, through their translation into legal systems, and are frequently inscribed in the national constitution, the highest legislation of the land (Owusu-Dapaah, 2015).

In Ghana, there is growing concern about patients' clinical experiences and healthcare in general. This concern is illustrated by the media's regular accusations against healthcare institutions and professionals, as well as cases filed before courts and quasi-judicial organizations. On September 2012, the media reported that a 26-year-old woman who went for a caesarean section at the then Brong Ahafo Regional Hospital in Sunyani was furious

at the medical team that took the operation for a tactless act that nearly cost her life (News Ghana, 2012). The media reported that the situation left the woman barren because the team left an operation towel in her abdomen. Ms. Ernestina Adade Konadu reportedly went through the ordeal two years ago when she went to the hospital to deliver. Consequently, the woman, whose first attempt at having a baby resulted in this disastrous manner went to court to demand GHC150, 000 as compensation from the hospital (Kuuku, 2014). The botched caesarean section, in the process of which Ms. Konadu lost her baby, after which she went home with another complication, took place on October 7, 2010. Ms. Konadu endured severe abdominal pains for over a year before diagnosis at a different health facility, revealed that the pains she had been experiencing were the result of an object lodged in her abdomen. A subsequent operation to remove the object revealed an operation towel which had been left in her abdomen after the caesarean section a year earlier. According to her medical report, the operation to remove the towel rendered the victim barren, meaning that she could no longer conceive and bear children. Moreover, her medical condition has so deteriorated that she can no longer engage in any hard work. After investigations into the matter, the authorities of the Brong Ahafo Regional Hospital confirmed and recognised the incidence of negligence on the part of the medical team but said the hospital was not in a position to pay compensation to Ms. Konadu. Ms. Konadu therefore, appealed to the Minister of Health, all relevant statutory bodies and the coalition of non-governmental organisations on human rights issues to step in to ensure that the right thing was done to save other patients from suffering similar fate. According to her, the Brong Ahafo Regional Chief State Attorney, Madam Afia Serwaa, who was also counsel for the Brong Ahafo Regional Hospital, had warned her to back down on her demand or

she (Madam Serwaa) would go public with Ms. Konadu's medical condition. (Owusu-Dapaah, 2015, p.96).

The issues raised by healthcare and medical practice that makes headlines reveal multiple layers of complexity that extend beyond the micro-issues of doctor-patient relationships to macro-thematic areas such as access to healthcare and the regulation of ethically sensitive medical advances imported into Ghana (Owusu-Dapaah, 2015).

A review of some of the rights enshrined in Ghana's 1992 Constitution will help us appreciate the issues better especially when it comes to human-rights-based approach to Healthcare Law. Article 12(1) expressly extends the obligation to respect and uphold the Constitution's Fundamental Human Rights and Freedoms to the government as well as natural and legal people, inasmuch as the provisions apply to them. This article plainly implies that the Fundamental Human Rights and Freedoms (FHRF) declared in broad terms with regard to the state could be enforced against people and even non-state organizations. Article 13 specifically guarantees the right to life in negative words.

Personal liberty is protected in positive language in Article 14, with a number of allowed derogations. Article 15 affirms the inviolability of human dignity and the prohibition of torture and cruel and humiliating treatment. Article 18 guarantees the right to privacy and confidentiality. The freedom of information is also guaranteed by the Constitution. Article 28(4) protects a child from being denied medical treatment solely because of religious or other beliefs. In fact, the Constitution provides incapable people the right not to be denied medical treatment solely because of religion or other beliefs.

Article 17(2) contains a general anti-discrimination provision that states that "a person should not be discriminated against on the basis of gender, race, color, ethnic origin, religion, creed, or social or economic status." This can also be used to counter any type of discrimination in the healthcare context. According to Article 33(5), "the rights, duties, declarations, and guarantees relating to the fundamental human rights and freedoms specifically mentioned in this Chapter shall not be regarded as excluding others not specifically mentioned which are considered inherent in a democracy and intended to secure man's freedom and dignity."

Based on the aforementioned legal provisions, it is suggested that, in addition to drawing on interpretations of rights similar to those highlighted above from other jurisdictions and international human rights jurisprudence, other rights that enhance healthcare and patient dignity that exist in other democratic jurisdictions but are not present in Ghana, could be incorporated into Ghanaian law. Recent statutes in Ghana specifically provide rights of direct application to healthcare, which are related to the FHRF's constitutional stipulations.

The Public Health Act of 2012 (Act 851) and the Mental Health Act of 2012 are two acts worth mentioning here (Act 846). Act 851 specifically recognizes the right of clinical trial participants to provide informed consent and grants legal status to the Patients' Charter, which was introduced by the Ghana Health Service over a decade ago. Act 851 specifies specifically that "the principles established in the Sixth Schedule [of the Act] shall apply to all persons who relate to patients or clients." As a result, all healthcare professionals and health institutions, whether public or private, are required to respect and uphold the rights enshrined in the Charter.

In addition to the above narrated episode, the have been other reported cases useful for a general understanding of the trend of medical negligence in Ghana. In particular, media report of August 5 2021 suggested that an Accra High Court has ordered the Nyaho Medical Centre in Accra, one of Ghana's leading private medical hospitals, for the release of the medical record folder of a female client who had sued the hospital for medical neglect and misdiagnosis (Agbenorsi, 2021). The claimant, a 29-year-old woman demanded her medical file after alleging excessive carelessness and misdiagnosis by the hospital where she sought medical care during her pregnancy. According to court documents the woman requested her medical folder from the hospital after the hospital failed to diagnose her ectopic pregnancy, which nearly resulted in her death. Following an emergency lifesaving surgery at a different hospital, the patient kept requesting for her complete medical records from the Nyaho Medical Centre since 2019 but to no avail, prompting the decision to go to court to compel the facility to release the records.

In a similar case of medical negligence, the 37 Military Hospital was also hit with a legal action against it in July 2021. The family of a 48-year-old patient, Solomon Asare-Kumah, who died after being hospitalized to the hospital, sued the facility's management for medical malpractice. In a letter of summons filed by the family's lawyer, they named erroneous insertion of an oxygen tube and malfunctioning of a surgical drill, among other things, as the causes of Solomon Asare- Kumah's death. According to the writ, the emotional anguish caused by Solomon Asare- Kumah's death resulted in the death of the deceased's father. The family at the time was asking the court for damages in excess of GH₵ 2 million from the 37 Military Hospital (Obu, 2021).

Furthermore, Ridge Hospital faced a GH₵ 5 million negligence lawsuits from a man whose wife and baby died at the hospital in 2020. This prompted the Ghana Diaspora Women Organization to demand the immediate suspension of two doctors and nurses accused of negligence that resulted in the death of the patient. The prescription of incorrect medication was thought to have contributed to the death of Madam Esther Sosuh, the wife of Dr. Emmanuel Kuto, the Institute of Languages' Director. Dr. Kuto's wife, 48, was diagnosed with a hernia and was having treatment after arriving to the facility on June 21, 2020. According to the group, just too many lives have been lost due to inexcusable negligence, and enough is finally enough. The organization further demanded that the Director-General of the Ghana Health Service and the Director of Ridge Hospital immediately suspend the two doctors and nurses involved in this alleged affair, since their behaviour was considered unethical in the medical profession (Obu, 2021). These cases demonstrate how terrible medical negligence is in Ghana. Despite this, only a few people are typically able to initiate legal action against these health facilities, and legal costs can sometimes be a barrier.

In another context, the 37 Military Hospital was fined GH₵ 1, 075,000 in July 2021 for the irresponsible death of a 27-year-old lady during childbirth in November 2015. Helena Brema Nyamekye, who was a Ph.D. student at the time of the incident, was claimed to have requested a cesarean section as her preferred way of delivering. Doctors, however, ignored her request and forced her into normal labor. The father and husband were each awarded GH₵ 400,000.00 in damages for loss of life expectancies; GH₵ 50,000.00 in damages for mental distress; and GH₵ 100,000.00 in damages for pain and suffering to the baby, Yaw Nyamekye. The Court also granted Yaw Nyamekye GH₵ 50, 000.00 in

disfigurement damages, GH₵ 50, 000.00 to primary caretakers, and an extra GH₵ 25,000 in damages (Obu, 2021).

In 2021, the Sam-J Specialist Hospital was also hit with a GH₵ 326,456 fines as compensation for medical malpractice that resulted in a baby's right arm becoming paralyzed. The hospital and its owner, Dr. Amoo Mensah, a specialist obstetrician and gynecologist, were found by the court to have negligently failed to uphold professional medical standards in providing antenatal care to the plaintiff. The amount included an award of general damages of GH₵ 200,000 and a cost of GH₵ 20,000. Although the Plaintiffs (an expectant mother and her husband) sought the assistance of the private health facility and its owner for the best medical care to deliver a healthy baby, the court presided by Justice Doreen G. Boakye-Agyei found that their expectations were dashed due to the Defendants' failure to uphold their own ethical and professional standards, leaving the child handicapped for life. The Court determined that the child's substandard medical care caused Klumpke's palsy, a paralysis of the arm caused by damage to the spinal nerve network brought on by a challenging birth (Obu, 2021).

According to the trial's facts, the couple, who were represented by Mr. Emmanuel Darkwa, their attorney, disclosed that they requested antenatal care from Sam-J Specialist Hospital in March 2017. The hospital's owner, Dr. Amoo Mensah, an obstetrician and gynecologist, was then assigned to care for the pregnant wife. The plaintiffs, who filed a lawsuit against the hospital in June 2019, claim that neither the doctor nor the hospital provided adequate professional medical care. They also claim that on one occasion, a pregnancy scan was performed, and it was discovered that the baby was an unusual size and weight of 3.85kg at 37 weeks, which would normally make delivery challenging (Obu, 2021).

They claimed that despite the expecting mother's worries over the size of the unborn child, the doctor disregarded them, and that during a subsequent appointment, the doctor gave the expectant mother medication without explaining its intended use. She added that despite not having diabetes, she only learned at the pharmacy that the medication was for the condition. The plaintiffs claim that after learning that gestational diabetes was to blame for the baby's increased size and weight, they discovered that neither the hospital nor the doctor had given them any guidance on how to handle the condition prior to the baby's delivery (Obu, 2021). The plaintiffs argued that Dr. Mensah and his hospital's method of delivery was to blame for the harm done to their newborn son. The plaintiffs had to seek medical treatment for the injury at other hospitals in Ghana and India, paying significant sums in the process. With the exception of interest on the different costs expended, the court granted all of the reliefs requested by the plaintiffs (Obu, 2021).

2.4 The Ghana Health Service Patients' Charter

The Ghana Health Service Patients' Charter is a document that outlines the patient's obligations and rights throughout the healthcare-seeking process. The Commission on Human Rights and Administrative Justice (CHRAJ) and other stakeholders in the health sector worked with the Ghana Health Service to develop the Charter (representations from some professional bodies, training institutions and the private sector). The Charter was formally introduced in 2002 (CHRAJ, 2002), and the GHS briefed the media about its existence in 2005 at a significant workshop. The session was organized with the intention of collaborating with the media to raise awareness, according to representatives of the service.

Additionally, to inform patients and the general public about the provisions of the Charter, the GHS and its partners have relied heavily on the deployment of posters in the wards of the majority of public hospitals and at offices. The Patients' Charter's main message is a request to healthcare professionals to support and respect the rights and responsibilities of patients/clients, families, healthcare professionals, and other healthcare providers.

Additionally, patients' age, gender, and other distinctions, as well as the requirements of patients with impairments, are taken into consideration, as are the patients' sociocultural and religious backgrounds. The Patients' Charter in the United Kingdom served as a model for the creation of the Charter. The Patient's Charter discusses the following issues: The individual's right to the best possible healthcare, within the limits of the nation's resources, that is conveniently accessible, equitable, and comprehensive. Respect for the patient as an individual with a right to decide on his or her medical treatment options. Rights to protection from discrimination based on race, nationality, language, religion, gender, age, and certain illnesses or disabilities. The patient's or client's obligations to maintain their own and the community's health through simple preventive, promotion, and curative measures. Every healthcare professional is supposed to support and respect the responsibilities and rights of patients, clients, and families. Additionally, healthcare professionals are supposed to be considerate of the patient's age, gender, and any other characteristics as well as their sociocultural and religious origins, as well as their needs if they have a disability.

In Ghana, patients have access to about 14 different rights, according to the Patient's Charter. Therefore, irrespective of ethnic background, age, sex, or religion, everyone receiving healthcare is eligible to enjoy all these rights. The rights comprise:

1. The patient has the right to quality basic healthcare irrespective of his/her geographical location.
2. The patient is entitled to full information on his/her condition and management and the possible risks involved except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent.
3. The patient is entitled to know of alternative treatment(s) and other healthcare providers within the service if these may contribute to improved outcomes.
4. The patient has the right to know the identity of all his/her caregivers and other persons who may handle him/her including students, trainees and ancillary workers.
5. The patient has the right to consent or decline to participate in a proposed research study involving him or her after a full explanation has been given. The patient may withdraw at any stage of the research project.
6. A patient who declines to participate in or withdraws from a research project is entitled to the most effective care available.
7. The patient has the right to privacy during the consultation, examination, and treatment. In cases where it is necessary to use the patient or his/her case notes for teaching and conferences, the consent of the patient must be sought.
8. The patient is entitled to the confidentiality of information obtained about him or her and such information shall not be disclosed to a third party without his/her consent or the person entitled to act on his/her behalf except where such information is required by law or is in the public interest.
9. The patient is entitled to all relevant information regarding policies and regulation of the health facilities that he/she attends.

10. Procedures for complaints, disputes and conflict resolution shall be explained to patients or their accredited representatives.
11. Hospital charges, mode of payments and all forms of anticipated expenditure shall be explained to the patient prior to treatment.
12. Exemption facilities, if any, shall be made known to the patient.
13. The patient is entitled to personal safety and reasonable security of property within the confines of the Institution.
14. The patient has the right to a second medical opinion if he/she so desires.

While the patient is free to exercise the rights listed above, there are also obligations placed on each patient. These obligations are related to the patient's own health, and each patient is required to give their complete cooperation to the medical professionals. According to the patient charter, patients are accountable for the following:

1. Providing full and accurate medical history for his/her diagnosis, treatment, counseling and rehabilitation purposes.
2. Requesting additional information and or clarification regarding his/her health or treatment, which may not have been well understood.
3. Complying with prescribed treatment, reporting adverse effects, and adhering, to follow-up requests.
4. Informing his/her healthcare providers of any anticipated problems in following prescribed treatment or advice.
5. Obtaining all necessary information, which has a bearing on his/her management and treatment including all financial implications.

6. Acquiring knowledge, on preventive, promotive, and simple curative practices and where necessary as well as seeking early professional help.
7. Maintaining a safe and hygienic environment in order to promote good health.
8. Respecting the rights of other patients/clients and Health Service personnel
9. Protecting the property of the health facility.

The Patients' Charter provides that these rights and obligations must be exercised by qualified and recognized representatives for patients or clients who are deemed minors or who, for various reasons, are unable to make wise decisions on their own.

2.5 Medication Administration Errors

According to the United States National Coordinating Council for Medication Error Reporting and Prevention, a medication error is:

> *Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing, order communication, product labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use.*

Studies have shown that medication administration errors one of the risk areas of medical and nursing practice and happens when a discrepancy occurs between the drug received by the patient and the drug therapy intended by the prescriber (Feleke et al., 2015; Tariq et al. 2023).

Probable factors contributing to this episode, data from my secondary sources show, include low health literacy, poor provider–patient communication, absence of health literacy, and universal precautions in the outpatient clinic (MacDowell et al., 2021). In Ghana, available data has shown that contributing factors of medication administration error include unavailability, staff factors, patient factors, prescription, and communication problems (Acheampong et al., 2016). The repercussions of receiving the incorrect prescription can be severe and can vary from digestive problems to death.

2.6 Obstacles to Reporting Medical Negligence in Ghana

In reality, the problem with suing public hospitals is that the public coffers would ultimately suffer if the plaintiff wins. This is due to the fact that the medical staff at these public facilities are government employees, and as a result, they are being sued for medical negligence by the Attorney General and the Ghana Health Service under the law of vicarious liability in tort. This situation poses a serious challenge to victims who may want to report incidences of medical malpractice in Ghana. For private hospitals, the process is quite easy to report medical negligence incidence, as a result, the health professionals at private hospitals take extra care when dealing with patients (Obu, 2021).

What makes it more challenging is that, when receiving treatment at a medical facility, patients are frequently attended to by staff members other than their treating doctor. You might have visits from more doctors who can assist with the diagnosis, a technician might do tests on you, and a nurse might do a number of different things. It can be challenging to pinpoint the precise culprit in a situation where medical negligence occurred. The concept of vicarious liability may be applicable in these and other circumstances. When a parent or superior entity, such as a hospital, is held accountable for the negligence of one of its

employees, this is known as vicarious liability. In a malpractice litigation, the respondent superior theory is applied in this way (Obu, 2021).

In Ghana, the majority of relatives of victims of medical negligence do not take legal action (Obu, 2021). Although the causes of the lack of legal redress are unclear, it is possible to believe that these might include a variety of factors such as lack of knowledge about the existence of legal redress, a lack of evidence to support the acts of negligence, the perception that medical staff would not be willing to testify, and the unwillingness of other professionals to testify against their colleagues.

2.7 Medical Negligence and the Right to Health

The significance of the above discussion is the desire to protect the right to health, a crucially noteworthy and fundamental right. As a result, in this section, I seek to detail the manner in which medical negligence is interwoven with the right to health. I begin by drawing attention to the fact that the right to health is provision of universal significance. The 1948 Universal Declaration of Human Rights, for instance, places premium on health as part of the right to an adequate standard of living. Article 25(1) specifically states that everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. The right to health is, again, crucially recognized as a human right under the 1966 International Covenant on Economic, Social and Cultural Rights. Article 12(1) provides that the states parties to this Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. This provision also involves the state

having a moral obligation to protect life by taking the necessary precautions to ensure that all citizens are well taken care of. The right to life must be protected because hospitals and healthcare institutions are government-controlled organizations and hence, have a moral obligation to protect life by applying the necessary safety measures.

At the national, healthcare delivery in Ghana is considered as uncompromising right. As a result, it is regulated by legal, policy and institutional frameworks. I detail this further below. At the legal level, given its unique importance, the health of every citizen is considered as an unfettered right under the 1992 Constitution of Ghana. Article 27 (1) of this Constitution provides that special care shall be accorded to mothers during a reasonable period before and after childbirth; and during periods, working mothers shall be accorded paid leave. The Constitution further mandates that everyone has the right to medical care, regardless of their capacity to provide consent. Article 30 provides that a person who by reason of sickness or any other cause is unable to give his consent shall not be deprived by any other person of medical treatment, education or any other social or economic benefit by reason only of religious or other beliefs. This provision, thus, makes access to medical care an uncompromising right. The Constitution further stipulates that no one, including hospitals and their offices, shall deny a person access to medical care if that person is unable to register his or her consent to participate in the particular right protected by the Constitution. Article 34 (2), which mandates that the President of Ghana report to Parliament on the status of this right, strengthens this constitutional provision even more.

At the policy level, it is imperative that the current health policy Ghana operates is said to be a derivation that takes its inspiration from the Directive Principles of State Policy (DPSP) under the 1992 Constitution. Among others, this requires the state as a duty-bearer

to ensure the realization of the right to good healthcare for people living in Ghana regardless of their colour, race, geographical location, religion and political affiliation. Owing to its importance, political actors are enjoined to be guided by the tenets of this policy so as to provide the needed leadership and support for its implementation (Kumbour, 2021). This policy is also believed to be inspired by the general national medium-term policy development framework as developed by the National Development Planning Commission (NDPC), as well as the Coordinated Programme of Economic and Social Development Policies (2017-2024).

Importantly, the establishment of the National Health Insurance Scheme (NHIS) in August 2003 was aimed at promoting access to equitable and quality healthcare for all citizens, irrespective of the individual's socio-economic background. The scheme is regulated by the National Health Insurance Act, 2003 (Act 650) as amended by As Amended by National Health Insurance (Amendment) Act, 2018 (Act 971). To ensure its effective implementation the National Health Insurance Authority (NHIA) was established to govern this scheme. To further ensure its effective and efficient implementation, a National Health Insurance Fund (NHIF) has been set up to fund the healthcare in the country. The significance of all these is that the wellness of every citizen of the country is a crucially important right that is at the heart of the state for which reason all legally appropriate means are used to ensure its success. It is within this context that acts that seek to frustrate this is considered as a fundamental human rights issue.

It is for this reason that, very often, suits against healthcare providers draw the state into it. In January 2023, the family of Solomon Asare Kumah, a 48-year-old man, took a legal action against the 37 Military Hospital together with a doctor, the Chief of Defence Staff

and government over what the family described as a medical negligence leading to the death of Kumah. The plaintiff demanded GH₵2 million damages for medical negligence leading to Kumah's death. The family averred that the death of Kumah at the hospital in October 2019 was resulted from breach of contract and negligence by the hospital and the doctor, Col. Dr Gao Appiah who took care of him. The suit, in part contended that "the hospital and its employees failed to exercise due care when they wrongly inserted Solomon's breathing tube under his skin thereby denying oxygen for a considerable amount of time and as such causing stain on his heart and other organs and thus causing his death."

2.8 Conclusion

In this Chapter, I reviewed the Subjective and Objective Theories of Negligence to give an account and interpretation of how medical negligence occurs. I further looked at an empirical review of relevant related literature which further explains the phenomenon of medical negligence under the following sub-themes: The Concept of Medical Malpractice, Ghanaian Laws and Medical Negligence, Cases of Medical Negligence in Ghana, Medical Negligence and Human Rights and Reporting Cases of Medical Negligence in Ghana among others.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter concentrates on the research methodology adopted to investigate and acquire relevant detailed information on the study of human rights implications of medical negligence in Central and Greater Accra Regions in Ghana. Specifically, the study sought to explore the experiences of victims of medical negligence in the Central and Greater Accra Regions of Ghana, examine challenges victims face in seeking redress of medical negligence in the Central and Greater Accra Regions of Ghana, and analyze human rights implications of medical negligence in the Central and Greater Accra Regions of Ghana.

The areas covered in this chapter include; the philosophical underpinning underlying the study, research approach, research design, study area, population, sample and sampling techniques, data collection technique and instrument, trustworthiness, method of data analysis and ethical considerations.

3.1 Philosophical Underpinning

The philosophical assumption that underpins this research is the interpretive research paradigm. Hammersley (2013) recommended the interpretive research paradigm as the best philosophical assumption to be used in the field of social sciences since it gives the opportunity for humans to interpret social realities from their own diverse contexts and experiences. He further explained that, though multiple reasons can be given to explain social happenings, to gain better, more accurate, and deeper insights into the phenomenon, it is important to examine the unique social contexts within which they occur and the self-narrative series of interpretations given by the social actors involved in such occurrences.

Drawing inspiration from Hammersley (2013), this study was underpinned by the interpretive research paradigm for three core reasons. First, the study did not necessarily seek to report facts but to report the various self-narrative interpretations that victims of medical negligence give for medical negligence cases in the Greater Accra and Central regions of Ghana.

Second, the interpretive paradigm was used because the study did not seek to make generalizations out of the data received but to use the relevant data received to describe in detail the situation of medical negligence in the study area from the diverse interpretations of the individual victims of medical negligence themselves.

In addition, the ultimate goal for selecting the interpretive paradigm was to interact directly and intensively with the research participants to understand and describe from their perspectives their experiences of medical negligence, what they have done to find justice, and their general challenges.

3.2 Research Approach

This study employed a qualitative research approach to get participants' views related to the human rights implications of medical negligence. Stake (2010) suggested the use of the qualitative approach as the appropriate approach to acquiring the most meaningful data in studies since it seeks to explain social realities through the lens of the persons directly involved in the given phenomenon understudy.

This study adopted the qualitative research approach and explored the self-narrative views of victims of medical negligence. Two major reasons informed this choice. First, the study aimed at using in-depth interviews to probe the personal experiences and thoughts of

participants in order to collect and analyze data in the exact words of participants on their experiences of medical negligence. This reason is in consonance with the argument put across by Kothari (2004) that the qualitative research approach focuses on people's lived experiences, behaviours, and emotions and involves a subjective evaluation of a social problem or behaviour through the use of flexible non-numerical data techniques such as in-depth one-on-one interviews, focus group interviews, observations, review of documents, etc. in acquiring relevant data. The second reason for the use of the qualitative research approach was to offer a complete description and analysis of the human rights implications of medical negligence without limiting the scope and the nature of participants' responses. The qualitative approach gave the participants the opportunity to probe further on questions posed for better clarification and to express themselves freely at length on questions they wish without any limitations.

3.3 Research Design

This study adopted the case study research design. Tuli (2010) argued that a case study is the main vehicle for driving the qualitative research approach since it helps to gain more authentic information in a research study. The decision for selecting a case study design was largely rooted in the argument put forth by Cousin (2005) that, a case study research design conducts an intensive study and interprets a scenario in a real-life context with the intention of increasing the apprehension of that specific scenario.

The major aim for the adoption of the case study design was thus to get up close with the participants to reveal their experiences of medical negligence. The study relied on a multiple case study design with Greater Accra and Central Regions as the cases for the study. The primary goal for relying on these two regions was to depict the case in a fully

comprehensive and multi-faceted manner in order to identify what is common and or specific about victims of medical negligence experiences.

3.4 Research Context

According to Article 30 (Right of the Sick) of the Republic of Ghana's 1992 Constitution, everyone has the right to medical care, regardless of their capacity to provide consent. The Constitution further stipulates that no one, including hospitals and their offices, shall deny a person access to medical care if that person is unable to register his or her consent to participate in the particular right protected by the Constitution. Article 34 (2), which mandates that the President of Ghana report to Parliament on the status of this right, strengthens this constitutional provision even.

Medical negligence comes under the law of tort which falls directly under civil law. The law of tort deals with civil wrongs leading to possible compensation. Under tort is the broader concept of negligence which per the case of the State vs. Tsiba (1962) 2 GLR 109 at p.111, Akufo Addo J.S.C (as he then was) defined negligence as: "the omission to take care where there is a duty to take care". Under negligence is the Standard of Care, and this is where the law of medical negligence is situated.

Medical negligence as defined by the case of Gyan vs. Ashanti Gold Fields [1991] 1 GLR 466 quoting with approval per McNair J. in Bolam vs. Friern Hospital Management Committee [1957] 2 All E.R. 118 at 121 stated that:

> "…In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his

> conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care…"

It is crucial to establish the fact that if a doctor or other healthcare provider operated in conformity with accepted medical standards, they are not guilty of medical negligence. The real diagnostic test for determining whether a doctor was negligent in their diagnosis or course of treatment is whether it has been demonstrated that they made a mistake that no doctor of reasonable skill would make if exercising reasonable care. When a patient visits a doctor, they anticipate receiving medical care using all of the doctor's expertise to solve their medical issue. The arrangement resembles a contract while keeping the fundamental components of a tort. A doctor has duties to his patients, and any of these duties that are broken can give rise to a claim of negligence against the doctor. Prior to performing diagnostic procedures and providing therapeutic care, the doctor has a responsibility to get the patient's informed consent. It is under this context that this study is been carried out in the Greater Accra and Central Regions of Ghana.

The Greater Accra Region is the smallest of the 16 administrative regions in terms of area, occupying a total land surface of 3,245 square kilometers or 1.4 percent of the total land area of Ghana. In terms of population, however, it is the second most populated region, after the Ashanti Region, with a population of 5,455,692 in 2021, accounting for 17.7 percent of Ghana's total population.

The Central Region in south Ghana is renowned for its elite higher education institutions and an economy based on an abundance of industrial minerals. The region is a hub of education in Ghana, with some of the best schools in the country. Whiles the area's economy is dominated by mining and fishing, the Central Region is also a major center of tourism in southern Ghana. And with some of the country's most beautiful coasts and national parks.

I chose Greater Accra Region because of its population size. The implication is that the Doctor-Patient ratio in the region is likely to be low as compared to other regions with relatively low populations in Ghana. On the other hand, I chose Central Region because of the elite population. It is assumed that majority of the people living in the central region fall within the elite population due to the availability of educational institutions.

3.5 Population

In this study, the target population was all victims of medical negligence. The accessible population on the other hand were all victims of medical negligence in the Greater Accra and Central Regions. The focus on victims of medical negligence gave the study a direction.

3.6 Sample and Sampling Technique

The study used the snowballing sampling technique to select a sample size of ten (10) respondents in totality from both regions. Snowball sampling or chain-referral sampling is defined as a non-probability sampling technique in which the samples have traits that are rare to find. This is a sampling technique, in which existing subjects provide referrals to recruit samples required for a research study. Two main reasons informed the selection of

this sample size. First, Borrego, Douglas & Amelink (2009) argued that to enhance manageability, stay economical and understand in detail a phenomenon under study in qualitative research, is important to focus on just a minor group out of an entire population. Hence the researcher used a sample size of ten (10) to be able to work within the stipulated timeframe for this study and also gain in-depth information from participants on their lived experiences of medical negligence. Second, the point at which data saturation was reached also helped to define the number of respondents selected for the study. Malterud (2012) argued that the more pertinent information the sample holds, the lower the number of participants needed. In this study, the required information power needed to answer adequately the research questions was attained by speaking to the 5th person in each case. Thus, additional information was not forthcoming except for a consolidation of ideas already shared by other respondents and taken notice of.

The snowballing sampling technique which is a method under non-probability, sampling technique was also adopted based on three central considerations: First, it is quicker to find samples. Referrals make it easy and quick to find subjects as they come from reliable sources. An additional task is saved for a researcher, this time can be used in conducting the study. Second, snowballing is cost-effective. This method is cost-effective as the referrals are obtained from a primary data source. It is convenient and not so expensive as compared to other methods. Third, it pays attention to sample hesitant subjects. Some people do not want to come forward and participate in research studies largely because, among other concerns, they do not want their identity to be exposed. Snowball sampling helps in this situation as they ask for a reference from people known to each other. There are some sections of the target population that are hard to contact. For example, if a

researcher intends to understand the difficulties faced by HIV patients, other sampling methods will not be able to provide these sensitive samples. In snowball sampling, researchers can closely examine and filter members of a population infected by HIV and conduct research by talking to them, making them understand the objective of the research, and eventually, analyzing the received feedback.

3.7 Data Collection Technique and Instrument

The researcher employed one-on-one interview sessions as the data collection technique to elicit the primary data on victims' lived experiences of medical negligence in the Greater Accra and Central Regions of Ghana.

Maharjan (2018) noted that an interview is a verbal interaction held in order to extract necessary facts about and from participants in a study. By way of reiteration, Davis (2021) also argued that an interview is an important data-gathering technique that involves verbal communication between the researcher and the participants in the research study. In other words, an interview in research is an interactive process in which the researcher interacts with the participants with the specific purpose of eliciting the needed information to address the research questions for a study.

The information elicited from the various interview sessions was written and voice-recorded for easy reference. The interview technique was used based on two aims. First, it was to get up close with the victims of medical negligence in the study area. Second, the researcher aimed at eliciting verbal responses from the participants of the study in order to probe further participants' responses to questions posed to gather a diverse and wide range of answers relevant to answering the research questions.

With regard to the data collection instrument, the semi-structured interview guide was used. Doyle (2020) postulated that a semi-structured interview is a type of interview where the researcher does not follow a strict question-and-answer format but rather ask more open-ended questions, allowing for a more comprehensive discussion with the participants. Here, questions that can simply be answered with 'Yes' or 'No' responses are avoided whilst the researcher focuses on questions that encourage two-way communication allowing for both the researcher and the respondents to ask follow-up questions to draw out more specific responses to address the research questions.

This study relied on the semi-structured interview guide to create a comfortable and conversational environment between the researcher and the participants in order to elicit in-depth and relevant information for the study. Also, the flexibility of the guide with regard to how questions can be posed and answered, largely informed its use. The researcher in using the semi-structured interview guide had the opportunity to probe areas based on the respondent's answers or ask supplementary questions for clarification. This helped to obtain in-depth information on the human rights implications of medical negligence in Ghana.

3.7.1 Trustworthiness

Polit and Beck (2014) stated that the trustworthiness of a research study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study. In simple terms, trustworthiness refers to the accuracy of a research study, its data, and its findings. The issue of trustworthiness is an important element in qualitative research study though what really constitutes trustworthiness is contested. However, this study relied on the four major tenets given by Guba & Lincoln (1994) as the criteria for assessing the

trustworthiness of a qualitative research study: credibility, transferability, dependability, and confirmability. These measures were necessary for two main reasons. First, it was to improve the validity and reliability of the data collection instrument. Second, it was to enhance the usefulness and integrity of the research findings.

3.7.2 Credibility

Korstjens & Moser (2018) argued that credibility in qualitative research establishes whether the research findings represent plausible information drawn from the participants' original data. It pushes for correct interpretations of participants' original views in order to promote confidence in the truth of research findings. The credibility of a research work helps to determine the veracity of the information gathered in a study.

To ascertain that the findings of this research are true and accurate, the researcher made sure that the data received represented accurately the participants and their shared experiences. Two measures were adopted to ensure this. First, the researcher used prolonged engagements with the participants in their respective regions. Thus the researcher spent not less than two (2) weeks in the Greater Accra and Central Regions to familiarize herself with the participants and build good rapport which helped with the free flow of information in the actual study. Second, the member-checking concept was adopted. Here, the data received from the interview sessions were documented and audio recorded. They were then read and played to respondents for them to authenticate their responses. Participants' reviews and feedback on the accuracy of their information helped to enhance the credibility of the study.

3.7.3 Transferability

To establish the element of transferability, the study explicitly described the research setting and participants, the sample size as well as the data collection technique and instrument used. This was necessary as it sought to serve as a guide for future works that will rely on participants with exact demographics to conduct a similar study. As Korstjens & Moser (2018) have suggested, transferability in the qualitative study looks at the degree to which the results of the research can be transferred to other contexts or settings with other respondents. In other words, transferability is interested in how the qualitative researcher demonstrates that the research study's findings are applicable to other contexts. In this case, "other contexts" can mean similar situations, similar populations, and similar phenomena.

3.7.4 Dependability

This study adopted the inquiry audit approach to enhance the dependability of the study. In this sense, experts in research methods and the research supervisor reviewed and examined the data collection process and its analysis in order to ensure that the findings were consistent and could be repeated. In addition, detailed coverage of the methodology was given. That is, an explicit sufficiently detailed description of the research methodology comprising the research setting, participants, sample size, and instrumentation was given. This was useful in helping readers and other researchers assess the extent to which research practices have been followed. The decision to do so is supported by existing practices as posited by Streubert (2007) who noted that dependability in a qualitative study refers to the consistency and reliability of the research findings and the degree to which the procedures are documented, allowing someone outside the research to follow, audit, and critique the

research process. In other words, dependability determines whether the same research findings would be consistently repeated when replicated in the same or similar context. In simple terms, it is the stability of research findings over time.

3.7.5 Confirmability

Guba & Lincoln (1994) contended that when credibility, transferability, and dependability are established, confirmability is also established. Confirmability refers to the objectivity of a researcher. That is the degree of neutrality in a research study's findings. It is therefore necessary that the findings of a study are based on participants' responses and not on the researcher's personal assumptions. This is aimed at eliminating all forms of researcher biases in the collection and interpretation of research data.

To ensure confirmability, the researcher applied the concept of an audit trail. Here, rich-thick information was given on every step that was taken in the data analysis process to explain the main rationale behind decisions made in this process. This helped to establish that the research study's findings accurately portrayed participants' responses.

3.8 Positionality and Reflexivity

My position in this study is an outsider. I am not a health worker neither am I a victim of medical negligence. Many critiques of qualitative work include complaints such as difficulty reproducing the procedure, difficulties with generalisability of findings, and a lack of scientific and methodological rigour (Patnaik, 2013). In response to these criticisms, I observed methodological reflexivity. According to Patnaik (2013), a methodological reflexivity attempts to guarantee that standardized methods have been followed in the conduct of research while respecting the researcher's relationship with the research. In

conducting interviews with participants, an interactive questioning strategy was adopted in order to develop rapport and encourage the participant to reveal more about their life.

3.9 Method of Data Analysis

Patton (2002) suggested that qualitative data analysis transforms data into findings that represent the unique views of each participant. This is because data are collected in words/text and analyzed in the exact thoughts or experiences of participants without subjecting them to statistical inferences.

In this study, the qualitative data were analyzed using thematic data analysis. Braun & Clarke (2012) posited that thematic analysis is a method for systematically identifying, organizing, and offering insights into patterns of meaning (themes) across a dataset. They further argued that this form of data analysis allows the researcher to see and make sense of collective or shared meanings and experiences of participants in a study. This study relied on a five-phased approach of thematic analysis namely: data classification, transcription, immersion, themes generation, coding of data, and description of data (Braun & Clarke, 2012 and Cooper & Schindler, 2011).

The first stage was the transcription stage. In this stage, the documented and the audio-recorded data were converted into manageable text data that depicted the exact views of participants for easy analysis. In this study, the English Language was the final text in which all translations were made. Hence, the transcription reproduced in full all spoken words and sounds including hesitations, false starts, cut-offs in speech, laughter, long pauses, etc. into manageable texts in the English Language.

The second stage was the immersion or familiarization of data stage. Here the researcher immersed herself in the data by reading and re-reading the transcribed textual data

repeatedly to acquaint herself with the full details of the text data derived from the interview sessions. This was done to facilitate the easy generation of themes and sub-themes.

The third stage was the theme generation stage. Here, themes and sub-themes were generated from the data received on the research questions posed bearing in mind the research objectives. This stage was made possible after the researcher had repeatedly read through the transcribed data to acquaint herself with the full details.

The fourth stage was the coding of the data. Here, numerical values and labels were placed on the participants and texts for descriptions of the data. For example, pseudonyms were used to enhance confidentiality, avoid revealing participants' identities, and ensure adequate protection of the private information derived from respondents. Thus, the names used in chapter four (4) to analyze the data received were only fictional names assigned to respondents.

The last stage was the description of the data. This was done by relating the sub-themes to the main themes with relevant literature cited to either confirm, refute or extend existing knowledge.

3.10 Ethical Considerations

Most research studies involve human participants and this makes it imperative for human research ethics to be followed for the protection of the dignity of the participants. This study conforms to the emerging human rights monitoring and reporting procedure as proposed by the United Nations Office of the Human Rights Commission (2011). In its *Training Manual for Human Rights Monitoring,* the Commission advised on the need to

adhere to strict ethical standards by reframing from what it refers to as "Do N Harm" in human rights monitoring and reporting. Here human rights officers (researchers and reporters, in this context) are to ensure that every effort to address effectively each situation arising under their mandate are made. At the same time, however, the Commission notes the challenge in achieving this by indicating that in reality, human rights reporters and researchers will not be in a position to guarantee the human rights and safety of all persons. Even so, it recommends that, it "is critical to remember that the foremost duty of the officer is to the victims and potential victims of human rights violations" (United Nations, 2011, p.88).

According to Blumberg et.al (2005) ethics is a branch of philosophy that deals with the conduct of people and guides the norms or standards of behaviour of people and their relationships with each other. Akaranga & Makau (2016) defined ethics as social norms for conduct that distinguishes between acceptable and unacceptable behaviour.

Research ethics is a branch of applied ethics and also defines rules of conduct for researchers. Fouka & Mantzorou (2011) argued that research ethics are the guidelines to be followed by researchers to protect the dignity of their participants and publish well the information that is researched. They suggested that such ethics must be followed by researchers to prevent the abuse of participants and the protection of human rights in research.

It is vital that a researcher observes appropriate research values at all stages to avoid research misconduct. This study relied on ethical considerations such as informed consent

and voluntary participation, anonymity, confidentiality, and risk of harm and plagiarism (Burns & Grove, 2005; Denzin & Lincoln, 2011 and Kumar, 1999).

3.10.1 Informed Consent and Voluntary Participation

Denzin & Lincoln (2011) argued that informed consent and voluntary participation is the pillar on which the data collection process in a research study is built. In affirmation, Fouka & Mantzorou (2011) also suggested that informed consent protects a participant's right to autonomy as it gives the opportunity for participants to know more about a research study and voluntarily give their consent to either be part or decide otherwise. Informed consent and voluntary participation, therefore, frown on researchers coercing participants for a study and give the power of freedom of choice to participants to decide whether to participate in a study or decline.

The core argument of this principle is that individuals can make informed decisions to voluntarily participate in a research study only if they have information on the possible risks and benefits of the research. Thus, it requires full disclosure of the intent of the research study, the information required of participants, and the possible physical harm or discomfort participants are likely to face. This is to allow the participants to make informed choices regarding their participation in a study.

In this study, the researcher sought the consent of the participants by giving full details and thorough explanations to participants on who the researcher is, the purpose of the study, the kind of data required from the participants, the significance of the study, mode of data collection and the participants' rights to withdraw from the study at any point in time they choose to do so.

3.10.2 Risk of Harm, Anonymity, and Confidentiality

Anonymity and confidentiality are important steps in protecting the participants from potential harm. This is because it provides an avenue for protecting participants. According to Denzin & Lincoln (2011) for example, participant anonymity means the participant's identity is unknown to the researcher. On the other hand, participants' confidentiality means the participants' identities are known to the researcher but the data were de-identified and the identity is kept confidential. It is important the identity of participants is kept confidential or anonymous to avoid the potential harm to participants on the sensitive information they give. Again, the researcher must consider the potential of harm to the participants, the researcher, the wider community, and the institution under study. Denzin & Lincoln (2011) argued that such harm can be discomfort or physiological, emotional, social, and economic in nature. Paying attention to these potential harms will help researchers come out with adequate measures to eliminate, isolate, and minimize the risk.

In this study, the principles of anonymity, confidentiality, and risk of harm were preserved by using pseudonyms, labels, and appropriate coding systems to conceal the names and real identities of participants in the data collection, analysis, and interpretations of the findings.

3.10.3 Plagiarism

Akaranga and Makau (2016) defined plagiarism as the practice where an author or researcher has to ensure that their work is original and devoid of texts, results or even expressions that are borrowed, manipulated, or used from other authors or publications without duly acknowledging the source. Plagiarism, they argued, is research misconduct

and has the potential to affect the integrity of the researcher. To avoid being caught up in the plagiarism web, the researcher has duly paraphrased great ideas by early writers on the topic and referenced all documents of other people used in this study.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.0 Introduction

This chapter presents the analysis and results in line with the objectives of the study and relevant extant literature. The study aimed at exploring the human rights implications of the experiences of victims of medical negligence in Ghana with specific reference to the Central and Greater Accra regions. The study was guided by the following research objectives: First, to examine patients' level of knowledge or awareness of the Ghana's Patient's Charter. Second to explore the experiences of victims of medical negligence in the Central and Greater Accra Regions of Ghana. Third, to examine challenges victims face in seeking redress of medical negligence in the Central and Greater Accra Regions of Ghana, and last but not least, to analyze human rights implications of medical negligence in the Central and Greater Accra Regions of Ghana. In line with the research objectives, the following research questions were posed: First, what have been the level of patients' knowledge about the Ghana's Patient's Charter? Second, what are the experiences of medical negligence among victims in Ghana's Central and Greater Accra Regions? Third, what obstacles confront victims of medical negligence in seeking remedies for medical negligence? And lastly, how does medical negligence affect a patient's right to health in Ghana's Central and Greater Accra Regions? The data analysis was done within the theoretical framework and the literature reviewed earlier in chapter two by employing the subjective and objective theories of negligence.

To ensure a better understanding of the victims' experiences of medical negligence, I was interested in exploring victims' awareness level of the Ghana Patient's Charter, and the

common medical negligence experiences using victims in Ghana's Greater Accra and Central Regions. The data gathered from the field revealed that participants have limited knowledge of the Patient's Charter of Ghana. The study also revealed that surgical negligence, prescription, and medication errors, and misdiagnosis are common experiences among victims. In the ensuing discussion, I take turns to detail these.

4.1 Patients' Level of Knowledge on Ghana Patients' Charter

Given that the welfare and interests of the patient is a fundamental concern under national and international human rights law, the state of Ghana has diversely demonstrated an appreciable commitment to protecting and promoting these. Importantly, earlier in chapter two, as part of the literature review, for example, it was indicated that as part of efforts to minimize the incidence of medical negligence in Ghana, the Commission on Human Rights and Administrative Justice (CHRAJ) and other relevant stakeholders (representations from certain professional bodies, training institutions, and the private sector) in the health sector working with the Ghana Health Service developed the Ghana Health Service Patients' Charter.

The Ghana Health Service Patients' Charter is a document that outlines the patient's obligations and rights throughout the healthcare-seeking process (Yarney et al. 2016). To ensure that this document does not only remain on the shelves but becomes common public knowledge, in 2002, the Charter was formally introduced. As part of this effort, the Ghana Health Service through a press release sensitized the general public on the document's existence three years after its formal introduction. The aim of this sensitization program was to collaborate with the media to raise awareness and also inform patients and the general public about the provisions of the Charter.

To ensure a higher impact awareness, the Ghana Health Service and its partners have, over the years, relied heavily on the deployment of posters in the wards of the majority of public hospitals and at offices. The Patients' Charter's main message is a request to healthcare professionals to support and respect the rights and responsibilities of patients/clients, families, healthcare professionals, and other healthcare providers. Additionally, patients' profiles including their age, gender, and other distinctions, as well as the requirements of patients with impairments, are taken into consideration, as are the patients' sociocultural and religious backgrounds.

However, data gathered showed that after over two decades of introducing and seemingly appreciably implementing the Patients' Charter, some Ghanaians still has limited knowledge about the Charter's provisions. This situation is particularly disturbing and defeats the initial purpose of its introduction, which is to create awareness on patients' and health practitioners' rights and responsibilities. The finding of the current study is consistent with Abekah-Nkrumah et al (2010) whose earlier studies suggested that majority of patients and a good number of health providers are worryingly unaware of the existence and contents of the Charter and that providers have generally not been able to carry out their obligations under the Charter as expected.

Interviews data from the field showed that eight (P1, P2, P3, P4, P6, P8, P9, P10) out of the ten participants are either unaware of or knew very little or nothing about the Charter's contents. Some participants who indicated their awareness of the Charter however, expressed ignorance about its specific provisions. P8, a participant indicated that he has no idea about that charter. *"I have seen it at the OPD [outpatient department] before but I didn't know that was what you are talking about. I don't know much about*

it though," he said (Interview with P8, December, 2022). Similar concerns were expressed by P1 who indicated that even though she has seen "such things posted at the hospital," she has not taken her time to find out exactly what they are. *"I have seen some posts in the OPD when I go to hospital but I have not read it before"* (Interview with P1, December 11, 2022).

The aforementioned concerns yield to significant gap when it comes to the goal of the Ghana Health Service Patients Charter, which is to enhance public knowledge of its contents among patients and the real awareness of the patients.

Situations such as these, as I demonstrate later in the chapter, leads to a wide range of abuses at the various hospital given that the Charter which aims to promote and protect the rights of patients remain relatively unknown. This calls for the right steps be taken to enable patients to seek out pertinent information and enhance their participation in the healthcare decision-making process.

4.2 Medical Negligence Experiences

4.2.1 Surgical negligence

In July 2020, a national newspaper, the *Daily Graphic* reported that an aggrieved man, Mohammed Mustapha, sued the Ridge Hospital, a Greater Accra Regional Hospital, for negligence that led to the death of his wife after a Caesarean section at the facility. The man the media reported, sought GH¢5 million in compensation for the death of his wife, Akua Nyarko Osei-Bonsu, 31, in December of the previous year and the associated trauma that he endured (Korankye, 2020). This and other similar reported and unreported episodes demonstrate the significant impact of medical negligence. In this section, therefore, I detail the nature and scale of medical negligence with specific focus on surgical negligence.

In many jurisdictions including even those with advanced medical systems, the correlation between lack of awareness of a patient's right and medical negligence cannot be adequately overemphasised (Mulheron, 2010). The situation in Ghana as revealed by this study is no different. Evidence from the Greater Accra and the Central regions suggest that a common form of professional negligence experiences in our health facilities is surgical negligence. Almost all surgeries have some level of inherent risk, but occasionally mistakes are made that should not be committed if a little bit of diligent service was provided. Common surgical negligence includes leaving foreign items inside patients or performing surgery on the incorrect part of the body. In certain severe situations, patients have even undergone incorrect surgery as a result of administrative errors. In addition to errors, surgical negligence also occurs when a procedure is unnecessary or when a patient's full consent was not obtained.

Interviews with participants revealed that surgical negligence is a common experience victims of medical negligence face in the Greater Accra and Central Regions of Ghana. P2, a resident of Winneba, narrated that she had a medical condition that required surgical operation. According to her, she noticed complications after the surgical operation was carried out; her condition became even worse. Upon several medical reviews at the healthcare facility and without any positive diagnosis, she decided to change healthcare facility. At her new facility, the doctors diagnosed that a piece of a foreign object, identified to be a surgical gauze that was used to clean the blood during the first surgery was left inside her body. She had to go through a second surgery to correct the condition. Akosua recounted her ordeal thus:

> *I had a problem that was to be rectified. I sought medical care and I was booked for surgery but unfortunately, after the surgery that was when the complication started. So apparently, a piece of the gauze that was used to clean the blood was left inside my body and so, after the situation, my condition became worse. I sought medical care elsewhere and then it was identified that was the problem* (Interview with P2, December 5, 2022).

Media reports and other public discussions reveal that such situations are not isolated in the Ghanaian public health system. In another worrying episode during this research, Adwoa shared her plight and how she suffered from what doctors identified to be cholecystitis, commonly referred to as gallbladder inflammation, a condition in which certain hard particles develop in the gallbladder (gallstones). According to Adwoa, a surgery was recommended by her doctor that she undergoes cholecystectomy, a surgical procedure to remove the gallbladder. Sometime after the cholecystectomy, she said, she experienced severe abdominal pain and decided to visit the hospital for medical review. According to Adwoa, she visited the hospital many times with complaints of pain in her abdomen but the doctors could not tell what exactly the problem was. She had to rely on painkillers to manage the condition she was going through. The pain grew worse and she visited a clinic where she was referred to a surgical centre with the suspicion that the pain was as a result of a ruptured appendix. A scan revealed a foreign body lodged in her paracolic gutter and had perforated part of her intestine. A second surgery was arranged for her during which a metallic suction nozzle that was left during her first surgery was removed from her abdomen. In a similar case P3, a 64-year-old man in Central region stated that he had an acute renal problem leading to painful urination. He

therefore went to hospital to see his doctor for advice. He avers that the doctor recommended a surgery to correct the medical condition. Following the doctor's recommendation, P3 went back to see the doctor that he was ready to undergo the surgery. According to him, the procedure involved being given a urethra, a tube that allows urine to flow outside the body. This surgery, he claimed, was successful since he did not feel any pain after the operation. To make sure he was fully recovered, after he was discharged, he was asked to come to the hospital for dressing while the tube was still inserted in his manhood.

The situation however, got worse one morning. When he went to dress it and went back home, he started experiencing swelling of his legs, ankles, and feet as a result of retention of fluids caused by the failure of urethra to eliminate water waste. He also felt severe pain, he therefore decided to go back to the hospital to seek medical care.

Kojo's situation involved a breach of a series of fundamental human rights issues. In particular, Article 7 of Ghana's Patient's Charter which is part of a corpus of the patient's rights succinctly provides that "The patient has the right to privacy during consultation, examination and treatment." The Article 7 of Ghana's Patient's Charter also provides that in cases where it is necessary to use the patient or his/her case notes for teaching and conferences, the consent of the patient must be sought. What is particularly worrying to P3 is that when he reported his swollen feet back to the hospital, a female nurse on duty on that particular day, started shouting that she would not dress it for him again because "if she has finished dressing it and I have gone home to undress it and the urine is flowing on my feet, she cannot do it again." (P3, December 15, 2022). P3 lamented that what even made his situation worse was that the yelling took place in

the full glare of other patients and third-parties. "There were many people in the hospital on that particular day, I had just a piece of cloth around my waist with my feet soaked in urine. And all the people around were looking at me," (P3, December 15, 2022). P3 lamented He felt that his confidentiality as enshrined in the Patient's Charter was sorely breached by the nurse in question.

Again, while Article 1 of the Patient's Charter mandates that "The patient has the right to quality basic healthcare irrespective of his/her geographical location," this provision was not adhered to in the case of P3. According to him, the nurse refused to attend to him. He, therefore, tried to pull out the urethra himself, but he could not do it, making him apply more force in order to pull. The pain after forcefully removing it, he said, was just unbearable for him. As a result, when the doctor came, he had to undergo a second surgery before the urine could flow normally. According to him although, he could urinate now, he is currently experiencing erectile dysfunction, which he links it to the situation he went through. P3 strongly believes that if the nurse had attended to him immediately, there would have been no need for the second operation. These incidents highlight some of the troubling disregard for the fundamental human rights by some healthcare professionals that occur in the course of their work, a situation that results in dangerous situations that their victims must deal with.

In every instance in the above episodes, the case of negligence can be and is established. Earlier in chapter two, using the views of Simons (1999), we emphasized three conceptions of negligence that are especially important in morality and law.

One conception emphasizes unjustifiable risk. This, Simons (1999) describes as a negligent act that creates an unreasonable or unjustifiable risk of future harm. A second emphasizes

evaluation according to a "reasonable person" criterion. Simons (1999) asserts that a negligent act, belief, or attitude is an act that a reasonable person would not perform or a belief or attitude that a reasonable person would not harbour. A third conception emphasizes culpable or unreasonable inadvertence: the actor, although not consciously aware of a risk, should have been aware. This conception is often employed to distinguish the negligent actor from the "reckless" actor who recognizes an unreasonable risk before taking it (Simons, 1999, p.54).

The first and the second episodes, as narrated by the victims, clearly fit in the first and the third conceptions as described by Simons (1999). The second conception helps us explain why the female nurse in the case of P3 knew very well her actions or inactions would lead to future harm to P3 (her victim) but went ahead to behave in such a manner as described by the victim. Applying the second conception of negligence, a “reasonable” nurse, would not perform the act as narrated by the victim even if the victim consciously undressed the wound leading to the abnormal flow of urine and the subsequent swelling of his feet.

4.2.2 Prescription and Medication Administration Errors

This section discusses another common medical negligence that yields to troubling human rights implications. Specific attention is paid to prescription and medication administration errors. Medication administration errors also referred to in some literature as medication dispensing error is the wrong dose, missing doses, and wrong medication that are most commonly reported occurrence in healthcare delivery.

It emerged in this study that medical administration error is, indeed, common medical negligence in the Greater Accra and Central Regions. P4, one of the participants narrated how she sent her baby boy to a hospital and at the pharmacy she was given wrong

prescription. This medication error, she said, worsened her son's condition. She narrated the situation as follows:

> *I sent my boy to hospital. When I went to the pharmacy to collect my drug, the person on duty mistakenly gave me a different person's drugs. He gave my son's drugs to different person, I think. When I gave my boy the drugs, he reacted to them [his condition became worse] and I sent the drugs back to the hospital and complained to those at the pharmacy. It was that time that they took his folder and realized they changed the drugs* (P4, December 9, 2022).

The above incident serves as a prime example of how medicine and prescription mistakes may harm patients and occasionally even result in deaths. In fact, over the years there have been reported cases in the media about how medication administration error has resulted in the death of patients in the country. In the story just narrated above, the child's situation could have been worse resulting in severe complications or even his death if the mother of the stated boy had not gone to complain to the nurses and kept giving the boy his medication.

This finding is consistent with Gandhi et al (2003) who assert that prescription and medication errors may be seen in the significantly varying error prevalence percentages reported around the globe. Avery et al (2012) for example reported that in the United Kingdom, over the course of a year, 12% of all primary care patients were affected by a prescription or monitoring error, rising to 38% in patients who were 75 years old or older and 30% in those who take five or more medications. Prescription mistakes were present in 5% of all cases (Avery et al, 2012).

Undesirable outcomes of prescription and medication errors include adverse drug reactions, drug-drug interactions, lack of efficacy, suboptimal patient adherence, and poor quality of life and patient experience (WHO, 2016). In turn, these may have significant health and economic consequences, including the increased use of health services, preventable medication-related hospital admissions, and death (Masotti, 2010). It has been estimated that in some countries approximately 6-7% of hospital admissions appear to be medication related, with over two-thirds of these considered avoidable and thus, potentially due to errors (Patel et al., 2007).

4.2.3 Misdiagnosis Errors

Closely related to the problem of medication administration errors is misdiagnosis error also referred to as medical misdiagnosis. This is a vital challenge in healthcare delivery, which this section seeks to examine. It is instructive to indicate that a medical expert failing to recognize the condition a patient is suffering from is considered a misdiagnosis. The most common episodes of medical misdiagnosis include: misinterpretation of lab/test results, lack of communication with the patient, false positive or negative, failure to recognize complications, as well as failure to diagnose a root cause or unrelated disease. Medical misdiagnosis also takes place where there is delay in identifying the condition. Multivalent factors account for this. Importantly, this study identifies lack of time with patients as a cardinal reason for misdiagnosis. It emerged from the study that given that medical providers have an overflowing caseload, they barely get to know their patients and their symptoms. In Ghana and most African and elsewhere, owing to the high doctor-patient ration, patient spend very limited time at the consulting room. The limited-time that patients get with their physicians is woefully inadequate to bring up all their concerns.

Situations such as this potentially and actually give rise to the doctors dismissing or overlooking some symptoms due to a lack of time.

Interviews with almost all of the ten participants showed that some doctors do not adequately listen to patients, a situation that leads to misdiagnosis. Some participants complained that doctors or health practitioners are not sensitive to the complaints of their patient who come to them. A participant noted,

> *I did same treatment for patient A, patient A did not experience that, so why is this woman exaggerating the pain she is going through? … like I said the body react in different ways and they are medical Doctors they know better…, if they had a little patience for me and reexamined me, they could have known that there was something wrong somewhere, but that wasn't done.* (Interview with P2, December 5, 2022).

Adwoa, another participant from Greater Accra also expressed her concerns thus:

> *I visited the hospital many times with complaints of pain in my abdomen but the doctors could not tell me the problem. I relied on painkillers to manage the pain. The pain grew worse and I visited a clinic where I was referred to a surgical centre with the suspicion [that] the pain was a result of a perforation of my appendix.* (Interview with P1, December 11, 2022).

The above episodes point to misdiagnosis. In both incidences, the victims visited the hospitals on several occasions, however, the physicians could not diagnose and identify the exact condition to allow appropriate treatment to be given and this led to life-threatening risks for the victims. Misdiagnosis, a common incidence of medical negligence, results in the death of many victims. It is vital for medical professionals to

pay attention to patient complaints and take the appropriate steps to prevent misdiagnosis.

4.3 Unwillingness to Pursue Legal Action

This section addresses a key research objective for this study, one which seeks to examine medical negligence victims' challenges in reporting and seeking legal action against medical practitioners, health workers, and or health institutions in Ghana's Greater Accra and Central Regions. A review of available records suggests that over the years significant legal actions have been taken by patients who feel aggrieved by medical malpractice or negligence. Yet, significant gaps continue to exist when it comes to the number of unreported cases. While the exact number of cases are unknown normative evidence suggest that an appreciable number of victims refuse to take up such cases owing to a number of factors (Obu, 2021).

A key finding of this study that demotivates victims of medical negligence from pursuing legal action against medical practitioners, health workers, and or health institutions is the amount of frustration they would go through to seek justice. Evidence from the study gathered from face-to-face interviews with surviving victims suggests that many victims of medical negligence do not take action against their perpetrators. Information gathered demonstrates that, among the ten sampled surviving victims, only one victim confirmed reporting the medical negligence episode and further sought legal action against the perpetrators and subsequently won the case following a long tussle of back-and-forth legal engagement.

The remaining nine participants did not report the incidents, nor did they take legal action against the perpetrators of the negligence acts. This point to the unwillingness on the part of victims, their families, and friends to report and seek legal action against medical practitioners, health workers, and health institutions. I was therefore interested in why some victims of medical negligence may not want to report or seek legal redress in the law court. It emerged in the study that, in Greater Accra and Central Regions of Ghana, victims of medical negligence and their relatives do not usually take legal action because of fear of victimization, the amount of time and energy involved, and the decision not to act as an act of kindness. In the ensuing discussion, I detail these.

4.3.1 Victimization

A key finding of the current study reveals that patients who experience medical malpractice decide not to report or pursue legal action because they fear immediate or future intimidation by healthcare workers whenever they visit a hospital. Participants emphasized that it will be challenging to create a supportive environment for healing since even members of the community will develop bad opinion about them. Expressing this, P5 a 44-year-old man, stated he has not reported any case since he strongly has the conviction that he could have been victimized by the hospital because at the end of the day he will return to the same hospital for healthcare services.

> *I have not been there [not reported] but I guess victimization by the hospital because at the end of the day, you go back to them. They are the ones that will give you the care that you need and you take them on*…? (Interview with P5, December 17, 2022).

4.3.2 Time and Energy

Over the years some reports on the legal system in Ghana have implicated the amount of time spent at the court and the frustration involved as a demotivating factor for taking legal recourse. This is particularly true of victims of medical negligence. This study has revealed that the participants share in the popular notion that going to court is time consuming and a waste of resources. This finding also corroborates with existing studies such as the work of Brodsky et al., (2004) which found that a compelling issue of concern for most victims is whether time and energy are available to maintain prolonged investment in legal efforts. Many persons have their lives so full or have so little available energy and resources that they will not choose or sustain a legal option. The current study found that victims of medical negligence may decide not to file lawsuits against healthcare professionals if they believe they would not have the time or energy to do so. A victim narrated,

> *I was going through a whole lot and I couldn't afford to let say, pick up that hospital when I needed money to rectify a problem that was giving me a serious health condition. All I wanted was to get my health rectified, to be in a better condition and not to take on that hospital* (Interview with P6, December 4, 2022).

The implication of the above statement is that it took a long time of back-and-forth before the ailment was correctly diagnosed. The participant believed he had very limited time and resources to take legal action against the medical facility. This finding corroborates with Brodsky et al., (2004) who found that a compelling issue is whether time and energy are available to maintain prolonged investment in legal efforts.

The study has identified that given the frustration victims go through, there is a gradually emerging phenomenon whereby they prefer to channel their concerns to their local radio and television stations. In a recent episode, a young student of nineteen years narrated how she was drugged and ganged raped by three men for a twenty-hour period in her hostel facility. A nurse who happens to be the caretaker of the hostel and a brother of the gang leader tried to cover the whole issue up offering basic medical support including giving her emergency contraceptive and taking her to the hospital over an anal fissure, a damage to the lining of her anus or anal canal as a result of anal sex she underwent as part of the gang rape. According to the young woman, although she reported the case to the police and arrest was made, the slow-paced nature of the proceeding has made her lose interest in the case hence coming to the studios of the television station to narrate her ordeal. This situation reveals the manner in which delays in the legal proceedings frustrates victims from pursuing certain abuses in society and medical negligence is no exception.

4.3.3 Sociocultural value of non-litigation

Studies have shown that incorporating international human rights provisions into domestic legislation and implementing them are particularly challenging for most of Africa (Atiemo, 2012). This situation is particularly so where sociocultural and religious values are involved. In traditional (and indeed contemporary) Ghanaian societies, letting go certain events in life is seen as a cherished value. As a result, people who are seen as litigious are often stigmatized and shun away with. In some communities, people who overly engage in litigation are often dubbed as antisocial. In times past, according to Atiemo (2013) such people were eliminated or treated differently even after death for

purposes of maintaining social cohesion and equilibrium. This reflects the situation of victims of medical negligence. This study has noted that some victims of medical malpractice choose not to report or pursue negligent claims out of fear of being mislabeled as litigious or sadists in their communities. Some people worry that if they report these offenders, such offenders would likely lose their jobs and their names would be associated with it. According to Kojo whose story we earlier narrated,

> *People told me that I should report the case. If I report the girl [female nurse] they will fire her from her job. So, I thought about it and said by now she is the only person in her family that they have used lots of resources to train her to become a nurse. If I let them fire her, her family will be disappointed*. (P3, December 15, 2022).

The implication is that the victim empathized with the perpetrator and decided not to take actions that could lead to the female nurse's removal from her post. What the victim did not know was that this same female nurse could act the same way toward other patients which could pose life-threatening conditions to her victims. This finding is in line with the observation of previous works such as Atiemo (2012) and Brodsky et al. (2004) which suggested that psychological elements are always associated with the decision not to sue. There are clear emotional and personal circumstances in which individuals decide not to sue. These decisions may not necessarily be made with full awareness of the nature of personal motives, and they may not be fully rational to the individuals involved.

4.4. Legal and Human Rights Implications of Medical Negligence

This section seeks to analyse the human rights issues related to medical negligence. In doing so, attempts were made to demonstrate some significant legal concerns in relation to medical negligence.

As has been made clear from the discussion so far, medical negligence has direct implications for the rights of victims. This is largely because, inter alia, the medical treatment decisions patients and their healthcare providers make can have a profound effect on patients' bodies and their lives. While medical practice has saved and improved human lives over the years, from what has been known so far and other documented and unreported cases, it can safely be said that if left unregulated, medical facilities can become a dehumanizing industry. Experts have maintained that the demand that patients be treated as unique human beings and the recognition of human rights in healthcare potentially can humanize both the hospital and the encounters with physicians and other healthcare professionals (Annas, 1990). For instance, in introducing his seminar work on *The Rights of Patients*, George J. Annas, perceptively observed that:

> *The most powerful concept shaping the practice of modern medicine is the recognition that patients have human rights. Respect for these rights can transform the doctor-patient relationship from one characterized by authoritarianism to a partnership and simultaneously improve the quality of medical care"* (Annas, 1992:1).

It is for this and many other reasons that in all jurisdictions, medical practice and healthcare delivery are regulated by legal, policy and institutional frameworks. In the discussion that follow, I seek to interrogate the core human rights implications of medical negligence in

two key areas of concern namely 1) medical negligence and right to health and 2) the law and medical malpractice.

4.4.1 Human Rights Implications of Medical Negligence

Data from this study reveals that there are significant number of unreported cases of concern. While participants are not fully aware of their specific rights, they are conscious of their general rights as patients. Some indicated that every individual has the right to good health. As a participant insisted, "every human being has the right to health, in fact not just health, but good one for that matter" (interview with P3). Some participants expressed the worry that going for medical treatment and ending up with a worse health condition is a violation of their right to good health and medical care. According a participant, at the time of the interview, she was on a permanent medication resulting from the effects of medical negligence she experienced. She recounted thus:

> *Currently, there is a medication that I have to take every now and then. So, that is what is keeping me alive. My condition is as a result of the impact of the anesthesia or the epidural injection I received. I guess anyone who has gone through this experience would be able to share the experience that I am going through* (P2, December 5, 2022).

Participants believed that medical negligence also has the tendency to also violate people rights to live. A participant emotionally indicated that it took divine intervention for him to survive and live again. According to him, "if not for God, probably I would have died out of it [surgery]" (P7, December 17, 2022).

The World Medical Association (WMA) Declaration of Tokyo (1975), Principle number 1 states:

> *The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.*

This notwithstanding, the discussion has shown that patients undergo a wide range of torturous ordeal in the name of seeking healthcare. The above episodes, in particular, point to the extent to which medical negligence can put its victims in a torturous situation and even leave them in a life-threatening situation.

4.4.2 The Law and Medical Negligence

The aforementioned discussion leads to a safer conclusion that the health and the life of the patient ought to be of ultimate importance to every healthcare provider and physicians. The rule of thumb is that as healthcare providers, they have a legal and moral duty to provide them with the best of medical care possible. In situations whereby acts of negligence lead to the patient being injured or dead, it may be considered medical malpractice. As a result, the courts have been particular about cases of negligence over the years. The case involving Solomon Kumah and the 37 Military Hospital narrated earlier provides evidence of the ways in which the cases of medical negligence have had significant legal implications. Specifically, tort of negligence in medical care has largely paid attention to medical wrongs leading to possible compensation. In deciding such cases, the courts have paid due attention to elements of negligence in terms of duty of

care; breach of that duty of care; causation, that is, a causal link between the patient's injury or death; and actual damage. Each of these elements are useful to successfully claim under the law of tort. Yet the primary step is to take into consideration whether there is a duty of care between the injured person and the person whose actions have caused it, that is the patient and the care provider or the physician.

In Ghana, the courts have defined negligence in the case of *the State v Tsiba* as "the omission to take care where there is a duty to take care" (GLR, 1962, 111). In *Gyan vs Ashanti Goldfields*, the court held that Negligence, whether it be a ground for a claim in a civil court for compensation or an essential ingredient in the constitution of a crime, is the omission to take care where there is a duty to take care, with this difference that whereas in a civil claim there are no degrees of negligence, such degrees exist in a criminal court. Section 51 of the Criminal Code, 1960, lays down the degree of negligence necessary to constitute the felony of manslaughter in the following terms: "Whoever causes the death of another person by any unlawful harm shall be guilty of manslaughter.

Provided that if the harm causing the death is caused by negligence, he shall not be guilty of manslaughter unless the negligence amounts to a reckless disregard for human life."

It is significant to note that the degree of negligence required in the other crimes provided in our Criminal Code falls very short of conduct amounting to recklessness. Section 12 of the Code provides that:

"A person causes an event negligently if, without intending to cause the event, he causes it by voluntary act, done without such skill and care as are reasonably necessary under the circumstances."

> *In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion, and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.* (GLR, 1991, 466).

What the above means is that in situations where a doctor or other healthcare provider operated in conformity with accepted medical standards and yet casualty occurs, they cannot be said to be guilty of medical negligence. The real diagnostic test for determining whether a doctor was negligent in their diagnosis or course of treatment is whether it has been demonstrated that they made a mistake that no doctor of reasonable skill would make if exercising reasonable care.

This view point is a best fit in the objective theory which explains that negligence is an objective fact rather than a subjective one. It is not a certain state of mind or type of vicarious liability, but rather a specific type of behaviour. Negligence is a violation of the duty of care. To be cautious implies taking measures against the negative consequences of one's actions. Thus, negligence means engaging in an activity that a reasonably prudent person would avoid. When a patient visits a doctor, they anticipate receiving medical care using all of the doctor's expertise to solve their medical problems. The arrangement of medical care resembles a contract while keeping the fundamental components of a tort. A doctor has duties to his patients, and any of these duties that are broken can give rise to a

claim of negligence against the doctor. Thus, in Wiafe vs Korle Bu Hospital, the court held that

> *The law allows an amount to be awarded to a winning party in cases of negligence to send signal to the other professionals and in this case health professionals to deal professionally with their patients. To give their patients the ultimate care as the situation demands. That failure with lead to payment of other compensations in addition to exemplary damages.*

The court lamented that "it is highly outrageous and unimaginable for health professionals to have left the metallic suction nozzle in the abdomen of the Plaintiff." It therefore awarded an amount of GHC100, 000.00 to the plaintiff and another GHC100, 000.00 award as exemplary damages.

As found in this study, owing to the sociocultural and religious moral values of the Ghanaian society, among other debilitating factors, cases of medical negligence are barely reported. This notwithstanding, the situation discussed in this section has also demonstrated that the state represented by the courts have been careful in handling such cases that are brought to its attention so as to safeguard the rights and welfare of its citizens.

4.5 Conclusion

In this chapter, I have discussed the experiences of medical negligence victims in Ghana's Greater Accra and Central Regions. I also paid close attention to several difficulties victims have that discourage them from seeking legal action in cases of medical negligence. I further discussed the implications of medical negligence for human rights.

CHAPTER FIVE

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.0 Introduction

This chapter presents a summary of the study. It puts together information gathered from the research objectives, reviewed literature, research methodology, and the major findings from field data. It also presents a conclusion based on the findings of the study and proposes some recommendations to address the challenges identified in the study.

5.1 Summary

In general, healthcare professionals have a moral, legal, and professional obligations to their patients. Healthcare providers have a duty to provide treatment to patients in order to save their lives. Legally and morally, health professionals must always respect the highest standards of professionalism and keep in mind that they have a duty to safeguard human life. However, occasionally during medical treatment, these ethical, professional, and legal obligations are not upheld either deliberately or unconsciously. The majority of the time, disregarding this fundamental obligation has resulted in various abuses and violations of human rights.

This study explored the human rights implications of the experiences of victims of medical negligence in Ghana with specific reference to the Central and Greater Accra regions. The study was particularly interested in the experiences of victims of medical negligence, the challenges victims face in seeking redress of medical negligence, and the human rights implications of medical negligence.

The study was guided by three specific research objectives. The first was to explore the experiences of victims of medical negligence in the Central and Greater Accra Regions of

Ghana. The second was to examine challenges victims face in seeking redress of medical negligence in the Central and Greater Accra Regions of Ghana, and the third was to analyze human rights implications of medical negligence in the Central and Greater Accra Regions of Ghana.

The study was organized into five chapters. Chapter one centers on the frame of the entire study, looking more broadly at the background to the study, the statement of the problem, the purpose of the study, the objectives of the study which informed the research questions, the significance of the study, the scope of the study, and the organization of the study.

Chapter two presents relevant and salient extant literature on medical negligence. The chapter two is divided into two main parts; the first deals with a theoretical review that employs the Subjective and Objective Theories of Negligence to give an account and an interpretation of how medical negligence emanates in contemporary Ghana. The second concentrates on an empirical review of relevant extant literature which further elucidates the phenomenon of medical negligence. Chapter three presented the methodology upon which the study is conducted. An interpretive research paradigm and a qualitative research approach were employed in the study. This study adopted the case study research design and the snowballing sampling technique to select a sample size of ten (10) respondents from both regions. I employed one-on-one interview sessions as the data collection technique to elicit the primary data on victims' lived experiences of medical negligence focusing on the Greater Accra and Central Regions of Ghana. In Chapter four, attention was paid to a discussion of the results and findings of the study. To ensure a better understanding of the victims' experiences of medical negligence, I was interested in exploring victims' awareness level of the Ghana's Patient Charter, and the common

medical negligence experiences using victims in Ghana's Greater Accra and Central Regions. The data gathered from participants revealed that participants have diverse awareness level ranging from a "no" to limited knowledge of the Patient's Charter of Ghana. The study also revealed that worrying challenges such as surgical negligence, prescription, medication errors, and misdiagnosis are common experiences victims undergo.

5.2 Conclusion

Health practitioners have a professional, legal, and moral duty to give medical assistance in order to save patients' lives. This notwithstanding, these legal, professional, and moral duties are sometimes consciously or unconsciously not upheld in the course of medical treatment. In this study, I explored the human rights implications of the experiences of victims of medical negligence in Ghana with specific reference to the Central and Greater Accra regions. I was interested in exploring victims' awareness level of the Ghana Patient Charter, the common medical negligence experiences as well as the legal and human rights implications of medical negligence. The data gathered from participants showed that participants have limited or no knowledge of the Patient's Charter of Ghana. The study revealed that surgical negligence, prescription and medication administration errors, and misdiagnosis errors were common medical negligence cases recorded in Central and Greater Accra Regions. The degree to which victims were (un)willing to pursue legal action against healthcare practitioners was greatly influenced by fear of victimization, time and energy required, and sociocultural value of non-litigation.

In times of human rights implications, the study also revealed that there is a correlation between medical negligence and grave violations of fundamental human rights of victims.

On the basis of the data gathered and analysis made thereof, the study concludes that notwithstanding the many years of its existence of the Ghana's Patients' Charter, some citizens are still unaware of its specific provisions. Given the grave consequences of this lack of awareness, there is a worry that if conscious efforts are not made to educate and sensitize the general public on the Ghana Patients' Charter, the fundamental aim of its development would be defeated leading to the continuous violation of the fundamental human rights of patients in Ghana.

5.3 Recommendations

Given that there is a "no" to low awareness on the Ghana Patient Charter's specific provisions among victims of medical negligence, the study recommends the need for intensive public education on basic health rights to create public awareness of the citizens' basic rights. The study, therefore, recommends that relevant state institutions such as the National Commission on Civic Education (NCCE), the Information Service Department (ISD), Commission on Human Rights and Administrative Justice (CHRAJ) and Civil Society Organizations (CSOs) should intensify their public education and sensitization on the specific provisions of the Patient Charter.

Moreover, this study found that many victims of medical negligence are reluctant to report cases of negligence and also pursue legal actions against perpetrators. It is recommended that the National Commission on Civic Education (NCCE), the Information Service Department (ISD), Commission on Human Rights and Administrative Justice (CHRAJ) and Civil Society Organizations (CSOs) should intensify public education and sensitization on the dangers of not reporting incidences of medical negligence.

In particular, the study recommends the need to make provisions to introduce the right to health and its associated rights to basic school curriculum. This way, pupils will be made aware of healthcare rights at the early age and when they transition into higher education to study to become healthcare practitioners, they would appreciate the need to protect patients' right to health.

Another key finding in the current study revealed that medical negligence has direct implications for the fundamental human rights of its victims. It is recommended that human rights courses as insisted by CHRAJ should be reused and integrated into health practitioners training curriculum and be made compulsory to all individuals willing to take up careers in healthcare services. This will encourage human rights approach to healthcare delivery in Ghana. This will help reduce the many reported and unreported episodes of abuses by health professionals.

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Appendix 1: Interview Guide for Medical Negligence Victims

Everybody is sick, whether they realize it or not, and the only way to get better is to seek out a suitable local medical center for treatment. A patient in a hospital can anticipate one medical error every day of their stay. Because of the prevalence of malpractice lawsuits, it is reasonable to conclude that contracting out medical treatment does not guarantee that proper care will be provided. I will want to explore your experiences of medical negligence, how it has affected you, and the human rights implications on your well-being.

1. Do you know about the Ghana patients' Charter?
2. What does the Charter say? Or what do you know about the Charter?
3. Do you know about medical negligence?
4. Have you ever been a victim of medical negligence?
5. How did it happen to you?
6. How was your experience of medical negligence?
7. What actions did you take against the health facility or the health worker?
8. If you took action against the health facility, what was the outcome?
9. If you did not take action against the health facility or the health worker, why did you not take action against them?
10. What challenges do you, as a victim of medical negligence face or are likely to face when you make attempt to take action against health facilities or workers?
11. How has medical negligence affected you?
12. How are you coping with the effects of medical negligence?
13. Do you see any human rights violations in medical negligence?
14. If Yes, what specific rights do you think are been violated when there is medical negligence?
15. What precautions will you give to patients who will seek or are seeking medical attention in the future or even now?