A COMPARATIVE ANALYSIS OF PATIENTS' RIGHTS AND THE NEED FOR PROTECTION IN INTERNATIONAL LAW

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I declare that A COMPARATIVE ANALYSIS OF PATIENTS' RIGHTS AND THE NEED FOR PROTECTION IN INTERNATIONAL LAW is my own work and that the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

_____ _____

Signature Date

Mr I Bamidele

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Now unto the King eternal, immortal, invincible, the only wise God, be honour and glory forever and ever, Amen.

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ABBREVIATIONS

A & E - Accident and Emergency

ACHPR - African Commission on Human and Peoples' Rights

AD - anno domini (Latin for “in the year of the Lord”)

ADR - Alternative Dispute Resolution

All NLR – All Nigerian Law Reports

ALLSA – All South African Law Reports

AU - African Union

BBC - British Broadcasting Corporation

BC - Before Christ

CBN – Central Bank of Nigeria

CC – Constitutional Court (South Africa)

CCG - Clinical Commissioning Groups

CFRN – Constitution of the Federal Republic of Nigeria

CG - Clinical Guideline

CME - Code of Medical Ethics

CNSGP - Clinical Negligence Scheme for General Practice

Constitution RSA – Constitution of the Republic of South Africa, 1996

COVID-19 - Coronavirus disease 2019

CPA - Consumer Protection Act 68 of 2008

CPC - Consumer Protection Council

CQC - Care Quality Commission

DVT - Deep Vein Thrombosis

ECHR - European Convention on Human Rights

ECtHR - European Court of Human Rights

ECOWAS - Economic Community of West African States

EMEA - European Medicines Agency

EOC - Public Health Emergency Operations Centre

ER - All England Law Reports

EU – European Union

FCCPC - The Federal Competition and Consumer Protection Commission

GDP – Gross Domestic Product

GMC - General Medical Council

GP – General Practitioner

HER2 - Human Epidermal Growth Factor Receptor 2

HIV/AIDS - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

HPSCA - Health Professions Council of South Africa

HRC – Human Right Commission (South Africa)

HSC Act - Health and Social Care Act, 2012

ICCPR - International Covenant on Civil and Political Rights

ICCPR - The International Covenant on Civil and Political Rights

ICESCR - International Covenant on Economic, Social and Cultural Rights

ICJ – International Court of Justice

IHR - The International Health Regulations

IIHCE - International Institute for Health and Care Excellence

IMS - The Information Management System

JCVI - Joint Committee on Vaccination and Immunisation

LPELR – Law Pavilion Electronic Law Report

MDCN - Medical and Dental Council of Nigeria

MDDS - Mitochondrial DNA Depletion Syndrome

MDG's- Millennium Development Goals

MDPT - Medical and Dental Practitioners Disciplinary Tribunal

MHCA - Mental Healthcare Act 17 of 2002

NCC - National Consumer Council

NCDC - National Centre for Disease Control (Nigeria)

NFCS - The No-Fault Compensation Scheme

NGN – Nigerian Naira

NGO - Non-Governmental Organizations

NHA - The National Health Act, 2014 (Nigeria)

NHI - National Health Insurance

NHIS - National Health Insurance Scheme

NHRC - National Human Rights Commission (Nigeria)

NHS - National Health Service

NICE - National Institute Care and Excellence

NIHCE - National Institute for Healthcare Care and Excellence

Nigerian Constitution - The Constitution of the Federal Republic of Nigeria 1999

NMA - National Medical Associations

NPSC - National Patient Safety Collaborative

NQB - National Quality Board

NWLR – Nigerian Weekly Law Reports

OAU - Organisation of African Unity

OECD - Organization for Economic Cooperation and Development

PCT - Primary Care Trust

R – Rex (The King/State)

SA – South Africa

SA Charter - National Patients' Rights Charter of South Africa

SA HRC- South African Human Rights Commission

SA NHA - The National Health Act 61 of 2003

SAHRC - South African Human Rights Commission

SCNJ – Supreme Court of Nigeria Judgement

SDG - UN Sustainable Development Plan Goal

SERVICOM - Service Compact (Nigeria)

SGDs - Sustainable Development Goals

TAC - Treatment Action Campaign

THPA - Traditional Health Practitioners Act 22 of 2007

The Code - The Code of Medical Ethics

The Fund - Basic Healthcare Provision Fund

The Panel - Medical and Dental Investigating Panel

UBTH - University of Benin Teaching Hospital

UDHR - Universal Declaration of Human Rights

UK – The United Kingdom

UN - United Nations

US/ USA – The United States of America

WACA - West African Court of Appeal

WHO - World Health Organization

WMA - World Medical Association

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CHAPTER 1: INTRODUCTION

1.1. Introduction and background: a historical perspective

The question of what patients' rights are, as well as their origin and the extent of their reach, is a subject of recurring jurisprudential thought across various jurisdictions; a subject which remains largely unsettled. This lingering inconclusiveness, however, is not an indication that the term "patients' right" is bereft of historical antecedence, the very term is, in fact, "cast in stone".[1] As far back as about 1754 BC, the sixth Babylonian king, King Hammurabi of Mesopotamia, attempted a fusion of the Mosaic law and the law of retribution, heralding the emergence of one of the earliest codified complete legal codes - the Code of Hammurabi.[2] Out of the two hundred and eighty two (282) rules in the Code, of great importance and relevance to this thesis is rule 218, which states that "if a physician makes a large incision with the operating knife, and kills him, or opens a tumour with the operating knife, and cuts out the eye, his hands shall be cut off."[3] The legislative protection of patients' rights is thus not a recent development; this is without prejudice to the postulations of Yount[4] that the idea of patients' rights had been in existence in America at least since the 1970s, when the American Patient's Association Bill of Rights was passed into law. Yount further stated that Europe had an earlier conversation on patients' rights and included same in international treaties and documents. Such documents include the European Convention of Human Rights, Fundamental Freedoms of 1950 and the International Covenant on Civil and Political Rights (hereafter "ICCPR") of 1966.[5]

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1 https://www.history.com/.amp/topics/ancient-history/hammurabi (Date of use: 21 September 2019). The original text of the Hammurabi Code was carved in basalt on a stele which is an upright stone slab.

2 https://www.history.com/.amp/topics/ancient-history/hammurabi (Date of use: 21 September 2019).

3 See also Hammurabi *The Code of Hammurabi* (translated from the original Akkadian by Harper RF) (The University of Chicago Press Chicago 1904) 221. The Hammurabi Code contains different standards of justice for the three social strata that existed in the Babylonia Society: The Propertied Class or the Gentlemen, the Freedmen and the Slaves. For example, rule 218 as quoted above is applicable only where the deceased is a gentleman or a freedman. Where a slave is killed or his or her eyes are injured during medical procedure, the physician must replace the same with another slave or pay half the value of the slave respectively – The Hammurabi Code, rules 219 and 220.

4 Yount L *Patients' Rights in the Age of Managed Healthcare* (Facts on Fire Incorporation United States of America 2001) 23-24.

5 Yount L *Patients' Rights in the Age of Managed Healthcare* 24.

From the above, it is evident that the legislative protection of patients' rights can be traced to the ancient years. However, the terms, "respect for patients' dignity" and "patients' rights" are believed to have a Hippocratic origin because patients' rights have been specifically employed and promoted since the early years as seen in the Hippocratic Oath,[6] and other codes of practice for healthcare workers which emphasize the importance of the patient at the centre of healthcare law and policy.[7] Cohen and Ezer[8] suggest that patients' rights originated from a consumerist approach, where patients who bore a great part of their healthcare costs started to show concern about human rights abuses in healthcare settings. Their concern was founded on the belief that patients are human beings with rights, and doctors must give their competence to treating them.[9] Regardless, the real origin of patients' rights as a distinct class of rights is uncertain, but the Universal Declaration of Human Rights (hereafter "UDHR")[10] is a solid modern-age foundation of the rights of patients, as it emphasizes the inalienable rights of human beings.[11] In order to better understand patients' rights, some conceptual definitions and clarifications will be made below.

1.2. An overview of a patient and rights

A patient

For the purposes of this thesis a patient is "a person who is receiving medical care, or who is cared for by a particular doctor or dentist when necessary."[12] A patient may also be referred to as a "user", by which term is meant "the person receiving treatment in a health establishment, including receiving blood or blood products, or using a health service."[13] The Oxford dictionary defines a patient as "a person receiving or registered to receive medical treatment."[14] The Osborn's concise law dictionary

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6 Miles SH *The Hippocratic Oath and the ethics of medicine* (Oxford University Press Oxford 2004) 13-14.

7 In the World Medical Association (hereafter "WMA") Declaration of Geneva (1948), it was stated that the "health of my patient will be my first consideration". There are also provisions bothering on the protection of the rights of patients in The Nuremburg Code; WMA Declaration of Geneva: International Code on Medical Ethics 2006; the WMA Declaration on the Rights of the Patients; and many more.

8 Cohen J and Ezer T "Human rights in patient care: A theoretical and practical framework" 2013 *HHR* 7-19.

9 Merakou K *et al* "Satisfying Patients' Rights: a hospital patient survey" 2001 *Nursing Ethics* 499-508.

10 https://www.un.org/en/universal-declaration-human-rights/ (Date of use: 24 July 2018).

11 http://www.who.int/genomics/public/patientrights/en/ (Date of use: 16 May 2018).

12 https://dictionary.cambridge.org/dictionary/english/patient (Date of use: 16 May 2018).

13 National Health Act 61 of 2003 (South Africa) s 1, National Health Act 2014 (Nigeria) s 64.

14 https://en.oxforddictionaries.com/definition/patient (Date of use: 16 May 2018).

defines a patient as "[a] person who by reason of mental disorder is incapable of managing his own affairs."[15] Earl Jowitt's dictionary of English Law defines a patient as, "a person of unsound mind, known before the Mental Treatment Act 1930, as a lunatic."[16] Essentially, following the foregoing definitions, a patient is a recipient of healthcare services. The etymology of the word has been diverse from English, to Latin as well as Greek. The English noun "patient" is believed to be derived from the Latin word *patiens* suggested to mean "I am suffering" or "one who suffers" or the Greek verb *paskhein*, meaning "to suffer".[17]

The difference in some of the definitions has become a matter of legal significance[18] because it tells on the description of who a patient is and whether a patient can hold a healthcare practitioner or facility responsible for failure of treatment.[19] This is central to the duty of care and a breach of it, which is one issue that has generated furore in defining a patient in emergency situations, especially where the patient is yet to be included on the record of the healthcare practitioner.[20] The argument as to whether the absence of a general duty of care can absolve a healthcare practitioner, seeing as (s)he is not a doctor or nurse to all persons, is a matter for legal debate.[21] The law of delict prescribes that a plaintiff must prove negligence by showing that the defendant owed him a duty of care, that there was a breach of that duty, and that the plaintiff suffered harm as a result of the breach.[22] The question that arises for unregistered patients and emergency cases, therefore, is whether the neighbour's principle will

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15 Woodley M (ed) *Osborn's concise law dictionary* 12th ed (Sweet & Maxwell Ltd United Kingdom 2013) 343.

16 Greenberg D (ed) *et al Jowitt's the dictionary of English law* (Sweet & Maxwell Ltd United Kingdom 2010) 1597.

17 https://en.wiktionary.org/wiki/patient (Date of use: 3 April 2020).

18 *Kent v Griffiths* [2000] 2WLR 1158, QB36.

19 See *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 428, *Kent v London Ambulance Service* [1999] Lloyd's Rep Med 58 compared to *Baker v Kaye* [1997] IRLR 219 and *Kapfunde v Abbey National plc* [1999] Lloyd's Rep Med 48.

20 *Re N* [1999] Lloyd's Rep Med 257.

21 McQuoid-Mason DJ "Public health officials and MECs should be held liable for harm caused to patients through incompetence, indifference, maladministration or negligence regarding availability of hospital equipment" 2016 *SAMJ* 575-577.

22 *F v West Berkshire Health Authority* [1989] 2 ALL ER 545.

apply,[23] as rights in law require a duty owed.[24] Regardless of the various jurisdictional applications for when the duty of care can be said to exist, the general rule is that without that duty by the healthcare worker or facility, the discussion on patients' rights will not exist.

Rights

Rights, which have been described as having the same etymology as the word "law",[25] may be traced to early codes such as the Constitution of Medina 622 AD,[26] the Magna Carta 1215,[27] the English Bill of Rights 1689,[28] the Claim of Rights of Scotland 1689,[29] the Virginia Declaration of Rights 1776,[30] the United States Declaration of Independence 1776,[31] the French Declaration of Rights of Man and the Citizen 1789,[32] the US Bill of Rights 1791, the UDHR,[33] the European Convention on Human Rights 1950,[34] the ICCPR,[35] and the International Covenant on Economic, Social and Cultural Rights 1966 (hereafter "ICESCR").[36]

Different schools of thought have advanced different descriptions of rights, as it is a widely used concept with varying definitions, depending on the perspective and sphere of application. Rights can be classified into natural and legal rights; positive and negative rights; individual and group rights; civil, political and economic rights; social and cultural rights; or common law rights and constitutional rights.[37] As discussed by

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23 *Donoghue v Stevenson HL* [1932] at 580.

24 Compare *Lowns v Woods* [1996] Aust. Tort Reports 81-376 (NSWCA) and *Egedebo v Windmere District Hospital Association* (1993) 78 BCLR with *Kent v Griffiths* [2000] 2WLR 1158, QB36. In the preceding cases the courts held that the health practitioners were negligent even though there was no existing doctor/patient relationship, as the doctors were either not on duty or it was not within their premises. In *Egedebo* the court held that the doctor was negligent because the doctor was close by and had the capacity and competence to respond.

25 https://www.etymonline.com/word/right (Date of use: 30 May 2018).

26 https://www.constitution.org/cons/medina/con_medina.htm (Date of use: 25 July 2019).

27 https://www.bl.uk/collection-items/magna-carta-1215 (Date of use: 25 July 2019).

28 https://www.legislation.gov.uk/aep/WillandMarSess2/1/2/introduction (Date of use: 25 July 2019).

29 http://www.legislation.gov.uk/aosp/1689/28/contents (Date of use: 25 July 2019).

30 http://edu.lva.virginia.gov/online_classroom/shaping_the_constitution/doc/declaration_rights (Date of use: 25 July 2019).

31 https://www.archives.gov/founding-docs/declaration (Date of use: 25 July 2019).

32 https://avalon.law.yale.edu/18th_century/rightsof.asp (Date of use: 25 July 2019).

33 https://www.un.org/en/universal-declaration-human-rights/ (Date of use: 24 July 2018).

34 https://www.echr.coe.int/Documents/Convention_ENG.pdf (Date of use: 25 July 2019).

35 ICCPR. This treaty was adopted by the UN General Assembly on 19th December 1966; https://www.echr.coe.int/Documents/Convention_ENG.pdf (Date of use: 25 July 2019).

36 https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-3&chapter=4&clang=_en (Date of use: 25 July 2019).

37 Emiri F *Medical Law and Ethics in Nigeria* (Malthouse Press Lagos 2012) 41. See also the dictum of Karibi-Whyte JSC in *First African Trust Bank Ltd v Basil Ezegbu* [1992] 9 NWLR (pt.264)132.

Sodipe,[38] rights have been described by means of various modifiers such as human rights, fundamental rights, basic rights, common rights, and such others that are specific to the holders of the rights in question; these rights are usually described as "rights of a beneficiary". Rights suggest a corresponding duty and any prevention or restriction on rights must be for a lawful reason. The Human Rights Act of 1998 (UK)[39] classifies rights into unqualified rights (which include the right to life in Article 2), qualified rights (which may be altered in a state of emergency), and limited rights (which include the right to privacy and family life).[40] For the purpose of this research, rights will be defined as an entitlement which must be given and can be demanded for.[41] Annas advanced a popular opinion when he mentions that many healthcare providers believe that patients should be more concerned about their health than about their rights, stating that "patients have needs not rights".[42] He, however, subsequently countered his early position by affirming that patients' decisions on their treatment options and their autonomy are also very important, as they have both needs and rights.[43]

Of the various classifications of rights, in a bid to aid its definition per usage, the justiciability of social and economic rights is a subject of debate in many countries.[44] The Constitution of the Federal Republic of Nigeria 1999 (hereafter "Nigerian Constitution"), for example, classifies social and economic rights as "fundamental objectives and directive principles of state policy" thus portraying them as mere ideals which are non-obligatory on the state.[45]

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38 Lokulo-Sodipe J "Withholding treatment from disabled new-borns and its effect on the right to life in Nigeria" 2009 *JLCR* 79-87.

39 http://www.legislation.gov.uk/ukpga/1998/42/data.pdf (Date of use: 6 June 2018).

40 See also *Procurator Fiscal v Brown* [2000] UKPC D3 and Human Rights Act 1998 (UK).

41 Areen J *et al Law, science and medicine* 2nd ed (The Foundation Press Inc. New York 1996) 698. This will be better examined in a later chapter of this research.

42 Annas GJ *The rights of patients: The basic aclu guide to patient rights* (Springer Science & Business Media London 1992) 3.

43 Annas *The rights of patients* 3.

44 Toebes B *The right to health as a human right in international law* (Books for Civil Society Hart 2001) 6-7.

45 Nnamuchi O and Metiboba S "Healthcare organization and financing" in Lyioha I O and Nwabueze RN (eds) *Comparative health law and policy: critical perspectives on Nigerian and global health law* 1st ed (Routledge London and New York 2015) 22; see also Nnamuchi O "Kleptocracy and its many faces: the challenges of justiciability of the right to healthcare in Nigeria" 2008 *JAL* 2.

Although as considered above, neither “rights” nor “patients” have a specific definition, patients’ rights will be examined in the following subsection, with a view to adopting a definition that will guide this thesis.

1.3. Patients’ rights

Patients’ rights in the global sphere can be gleaned from various sources, principal of which are the human rights instruments at international, national and regional levels.[46] The human rights of an individual are still applicable while (s)he is a patient, but there is an emphasis on the prevention of a perceived exploitation of the patient who is deemed vulnerable. The state has a primary obligation to provide facilities, amenities and infrastructure that enable patients and persons with special needs to enjoy all their rights to the fullest level like any other citizen would.[47] Flowing from the foregoing, patients’ rights are rights accruing to a patient, by virtue of him/her being a patient which can be demanded from healthcare practitioners and providers and are equally protected by law.

This research focuses on patients’ rights in some jurisdictions, the choice of which is explained below, and the context and the contents in each country is outlined below.

1.4. Choice of countries

The research ultimately concerns the rights of patients across the globe with particular focus on three countries as instantiations only, namely South Africa, Nigeria, and England in the United Kingdom (hereafter “UK”). These countries have been chosen in this study based on the connection in their legal systems and the accessibility of sources. South Africa, Nigeria and the UK are commonwealth countries with a shared Common Law history. The three countries are members of the United Nations

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46 See UDHR; the UN’s Convention on the Rights of the Child; UN General Assembly Resolution 44/25, November 20,1989; ICESCR; UN General Assembly Resolution 2200A[XXI], December 16,1966; ICCPR; Convention on the Elimination of All Forms of Discrimination Against Women; UN General Assembly, December 18, 1979; International Convention for the Elimination of all Forms of Racial Discrimination; UN General Assembly Resolution 2106 [XX], December 21,1965; Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment; UN General Assembly Resolution 39/46, December 10,1984; Convention on the Rights of Persons with Disabilities; UN General Assembly Resolution, December 13, 2006; International Alliance of Patients' Organizations; Declaration on Patient-Centred Healthcare 2006; Declaration on the Rights of the Patient, World Medical Association Assembly September/October 1981; Position Statement: Nurses and Human Rights, International Council of Nurses 2011.

47 *Van Biljon v Minister of Correctional Services* 1997(4) SA 441 (C).

(hereafter "UN"); and Nigeria and South Africa are members of the African Union (hereafter "AU"). Although the three countries share certain similarities, there are also some stark differences, a major one being the government health expenditure per citizen. In the UK, the average health expenditure per citizen is 3,175 United States' (hereafter US) Dollars, compared to Nigeria which is 10 US Dollars per citizen,[48] and South Africa with an expenditure of 230 US Dollars per citizen.[49]

I studied for my first degree in law in Nigeria, my second degree in the UK, and I am undertaking this research for a doctorate in South Africa. I am also a registered legal practitioner and law teacher in Nigeria. In addition, I am married to, and a father of a British citizen. I am therefore concerned about the rights of patients in these jurisdictions and in the world. Having been a patient in two of the three jurisdictions and related to patients in all three jurisdictions, I have recognised a sharp contrast in the approaches to patients' rights issues in Nigeria and the UK.

1.4.1 Patients' rights in the United Kingdom

In the UK, healthcare is managed by the National Health Service (hereafter "NHS") and some of the rights of patients are set out in the NHS Constitution first published in 2012 and last updated in 2015.[50] The NHS Constitution, renewable every decade, guides healthcare workers and patients and sets out rights of patients, staff of the NHS, and the general public.[51] It lists seven key principles which guide the NHS and the fourth of these principles is that "the patient will be at the heart of everything the NHS does".[52] It also lists among other principles, that the NHS provides a service available to all; works across organizational boundaries in partnership with other organizations in patients' interest; and is accountable to the public, communities, and patients.[53]

The NHS Constitution clearly presents the rights of patients under various headings and elucidates pledges by the NHS which are moral guides or soft laws and do not have the same force of law as statutes. The introduction to the patients' rights section

48 https://countryeconomy.com/countries/compare/nigeria/uk (Date of use: 10 July 2019).
49 https://countryeconomy.com/countries/compare/south-africa/uk (Date of use: 11 July 2019).
50 https://www.gov.uk/government/publications/the-nhs-constitution-for-england (Date of use: 24 July 2019).
51 NHS Constitution s 2.
52 NHS Constitution s 3.
53 NHS Constitution s 4.

of the NHS Constitution states that the Constitution protects each user's legal rights; it also states what to do when a user has not received the rights and pledges of the Constitution. Although they may not be legally binding, the pledges are a statement of commitment from the NHS to provide quality services.[54]

The rights of the patient enumerated in the NHS Constitution are arranged under seven major headings. The headings for the rights are: the right to access health services; the right to quality of care and environment; a right to nationally approved treatment, drugs and programs; the right to respect, consent and confidentiality; the right to informed choice; the right to involvement of the patient in his/her healthcare; and how to seek redress.[55] These are examined in brief below, and will be fully discussed in Chapter 5:

1. The right to access health services: This includes the right to NHS services, the right to appropriate care and treatment for the patient, and the right to expect that the NHS assesses community needs and meets those needs, hence improving the health of the society. The right of access to health services also includes the right to go to other European Economic Area Countries or Switzerland for treatment[56] and the right not to be discriminated against on various grounds including gender, race, disability and gender reassignment, amongst others.[57] Also included, is the right to access the services of the NHS within a reasonable time or to be provided with an alternative.[58] The commitments of the NHS under this right of access to health services include its commitment to - provide convenient and easy access to health services; make clear decisions for patient understanding; ensure a smooth transition of patients where they are being referred; and include the patients' carers and family members in the decision making for patients.[59]
2. The right to quality of care and environment: This includes the right to be treated with a professional standard of care[60] by qualified and experienced staff; the

54 NHS Constitution s 6(3a).
55 NHS Constitution s 6 (3a).
56 *Pretty v The United Kingdom* [2002] ALL ER (D) 286 (Apr).
57 NHS Constitution s 6(3a).
58 NHS Constitution s 6.
59 NHS Constitution s 7.
60 That is the minimum standard of care in the country. This is better considered in Chapter 2 of this research.

right to be cared for in a clean environment; to nutritious food for health; and a right to expect the NHS to monitor the quality of healthcare and improve it regularly. The commitment of the NHS to this right is to ensure best practices in care and treatment quality in the UK.[61]

3. The right to nationally approved drugs, treatments, and programs: This includes a right to drugs recommended by the National Institute for Healthcare and Care Excellence (hereafter "NICE").[62] A patient also has a right to expect rational decisions on the funding of drugs and treatment, as well as a right to receive vaccination under the national immunization program. This right also includes a pledge by the NHS, of its commitment to provide screening programs recommended by the National Screening Committee.[63]
4. The right to respect, consent and confidentiality: This includes the right to be treated with dignity and respect; the right to refuse and/or to accept treatment; the right to information about treatment and test options; the right to access health records; and the right to have patient information held secure. If patient information must be used, the patient has a right to be informed before its use; the patient's consent must be first obtained after (s)he has been informed on how his/her information will be used, with an additional stipulation to decline the use of his/her information for use other than for his/her treatment and where declination is impracticable, (s)he must be informed of the legal basis for such impracticability.[64] The NHS Constitution pledges, congruent to this right, to ensure that all involved in the patient's care have access to his/her records and those patients who have been admitted to hospitals do not have to share sleeping accommodations with patients of the opposite sex.[65] The Constitution also pledges to ensure anonymity for patient information sharing in research and where the information is identifiable, the opportunity for the patient to decline.[66]

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61 NHS Constitution s 3a.

62 NICE is an independent organization providing national guidance and advice on health and social care including on drugs and treatment in the UK. See https://www.nice.org.uk/about (Date of use: 22 May 2018).

63 NHS Constitution s 3a.

64 NHS Constitution s 8.

65 With a development in discussions of inclusivity, equality and diversity, this may become a more arduous task.

66 NHS Constitution s 8.

5. The right to an informed choice: This includes the right of the patient to choose a general practitioner; a right to information on the quality of local healthcare; a right to express preference for using a doctor within a practice; and the practice's obligation to try to comply. The patient under this broad right of informed choice has a right to make choices about NHS services and information to support the choices. The NHS Constitution also pledges, under this right, to inform patients about healthcare services within and outside the country and to offer clinical information which will help patients get involved in healthcare decision making.[67]
6. The right of the patient to be involved in his/her healthcare: This right includes the management of the patient, end of life decisions, carers and family members; and also includes a right to information about safety incidents which relate to the patient and have caused or might cause harm. The patient has a right to be involved in the planning of healthcare services either directly or through a representative. In line with this right, the Constitution makes tow pledges. First, to supply patients with all information they may require to influence and scrutinize the planning and delivery of NHS services; and secondly to work with patients, their families and caregivers to take greater control of patients' healthcare.
7. The right to complaint and redress: This is a foremost right and the last in the NHS Constitution. It is the real essence of rights,[68] as infringements which occur must have a mode of redress and remedy. This right encapsulates the right to complain about NHS services, the right to discuss complaints, the mode of handling complaints, and the expected duration for resolution.[69] A patient also has a right to know the outcome of his/her complaint, and that actions have either been taken or will be taken. The patient has a right to report to the Health Service Ombudsman or Local Government Ombudsman where a report to the NHS is unsatisfactory and has a right to compensation where there has been negligent treatment. A patient's right to redress means there can be a claim for judicial review where an NHS decision is deemed unlawful or unfavourable. The

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67 NHS Constitution s 9.

68 *Ibi jus Ibi remedium*, where there is a right in law, there must be a remedy; http://www.oxfordreference.com/view/10.1093/oi/authority.20110803110448446 (Date of use: 27 May 2018).

69 The NHS Litigation authority indemnifies NHS organizations in the event of claims.

> NHS commitment sequel to this right is also very important, as it pledges that patients will still be treated rightly and will receive support, irrespective of the fact that they have laid complaints. The Constitution also pledges to be empathic, to apologize when in error and to use lessons from complaints to improve the NHS.[70]

Cases abound as to the UK's attempt at protecting the rights of patients.[71] A notable case involving patients' rights protection is the case of *Re C (Adult: Refusal of Treatment)*[72] where C, who was a patient at Broadmoor and suffered delusional beliefs, was diagnosed with a gangrenous foot and needed an amputation. He refused to consent to this treatment believing God would heal him. The Court held that he was competent and upheld his right to refusal of treatment, even when the decision did not align with medical opinion and was deemed irrational. It is noteworthy that the foot made a remarkable recovery.

Patients may access healthcare in the private sector too, in which case the Human Rights Act may be relied upon to institute claims. It appears that private health facilities are largely considered unsafe because they have less expansive resources and fewer variations of skill and expertise.[73] It is posited that the case of Ian Stuart Paterson who was convicted for carrying out unnecessary breast surgeries on up to 1000 patients,[74] for instance, may be blamed on poor monitoring of the private sector's healthcare facilities.[75] The rights protected in this chapter are discussed in detail in chapter five.

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70 NHS Constitution s 8.

71 See for example: *Chester v Afshar* [2004] UKHL 41; *Airedale NHS Trust v Bland* [1993] AC 789; *Bolam v Friern Hospital Management Committee* [1957] ALL ER 118.

72 *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290.

73 Gold A "The safety of private hospitals" https://www.lexology.com/library/detail.aspx?g=aec22ac7-cb7f-47e5-8af5-6a5f71c79498&utm_source=Lexology+Daily+Newsfeed&utm_medium=HTML+email+-+Body+-+General+section&utm_campaign=Lexology+subscriber+daily+feed&utm_content=Lexology+Daily+Newsfeed+2018-12-05&utm_term (Date of use: 14 June 2019).

74 Topping A "Breast surgeon Ian Paterson jailed for 15 years for carrying out needless operations" https://www.theguardian.com/uk-news/2017/may/31/breast-surgeon-ian-paterson-sentenced-for-carrying-out-needless-operations (Date of use: 14 June 2019).

75 Lintern S "Policy and regulation: CQC warns real danger for safety in private sector hospitals" https://www.hsj.co.uk/policy-and-regulation/cqc-warns-real-danger-for-safety-in-private-sector-hospitals/7022135.article (Date of use: 14 June 2019).

1.4.2 Patients' rights in Nigeria

Patients' rights in Nigeria are not delineated as a special class of rights. Rather, they are subsumed under the general human rights category. The Nigerian Constitution protects directly, or supports indirectly, patients' rights which include the patients' right to life;[76] the right to dignity of human persons including the protection from torture, inhuman or degrading treatment;[77] the right to personal liberty with the exemption of certain persons including "persons suffering from infectious or contagious diseases, persons of unsound mind and persons addicted to drugs or alcohol or vagrants who may be kept for their own care or for protection of the community".[78]

Some of the other rights which the Nigerian Constitution also guarantees are the rights to freedom of thought, conscience, and religion which have been justified by case law,[79] and the right to freedom of movement[80] which is usually infringed upon in healthcare settings by detaining patients who are unable to pay hospital fees and mental health patients, or persons being treated for addictions. The Nigerian Constitution also guarantees a right to freedom from discrimination on the basis of sex, religion, ethnic group or political opinion;[81] this protection is questionable as it conflicts with the laws prohibiting same-sex marriages and relationships in Nigeria, which may be seen as promoting discrimination, especially considering the effect these conflicting laws might have on the right of access to healthcare.[82] It is, however, worthy to note that the Nigerian Constitution provides that if any other law is inconsistent with the provisions of the Nigerian Constitution, the Nigerian Constitution shall prevail, and that other law shall, to the extent of the inconsistency, be void.[83] This suggests that although the provisions of the Same Sex Marriage (Prohibition) Act may have a discriminatory undertone, the right of a Nigerian citizen, protecting him/her from discrimination shall be recognized.

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76 Nigerian Constitution s 33.
77 Nigerian Constitution s 34.
78 Nigerian Constitution s 35.
79 Nigerian Constitution s 38; *MDPT v Okonkwo* (2001) FWLR 542.
80 Nigerian Constitution s 41.
81 Nigerian Constitution s 42.
82 Same Sex Marriage Prohibition Act 2014 (Nigeria).
83 Nigerian Constitution s 1(3).

The National Health Act, 2014 (hereafter "NHA Nigeria"), which is currently the law guiding healthcare in Nigeria, although yet to be fully enforced, is also a major source of law for the protection of patients' rights in Nigeria.[84]

Other rights such as the rights to individual autonomy, consent, confidentiality, and prompt medical treatment are in the Code of Medical Ethics,[85] the Medical and Dental Practitioners Act,[86] or acknowledged through case law.[87] The right to health, which is a socio-economic right, is however regarded (as earlier stated) as a non-justiciable right. It is only aspirational, although provided for in chapter two of the Nigerian Constitution.[88]

The decision of the Economic Community of West African States (hereafter "ECOWAS") court in *SERAP v Nigeria*,[89] a case on whether the right to education is justiciable, serves as a guide on the debate as to whether the right to health is justiciable. Although the case concerns whether demands can be made by citizens to compel government to provide education, the right contested falls in the same constitutional category as the right to health. The ECOWAS court[90] held that since Nigeria was a signatory to the African Charter on Human and People's Rights, the law was enforceable. Judgements of this nature form the rational basis for this thesis' recommendation of regional and international protection which may direct governments and protect citizens, especially in the protection of patients' rights. This recommendation also underscores the need for regional and global laws which will protect citizens in the event of inadequate local legislations or conducts.

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84 National Health Act 2014 (Nigeria).

85 Code of Medical Ethics in Nigeria Code 19; Rules of Professional Conduct for Medical and Dental Practitioners http://www.mdcnigeria.org/Downloads/CODE%20OF%20CONDUCTS.pdf (Date of use: 21 May 2018).

86 Medical and Dental Practitioners Act Cap M8 LFN 2004.

87 *Ojo v Gharoro* (2006) 10NWLR, pt 987.

88 Nigerian Constitution chapter II. This chapter is only aspirational as it is rendered non justiciable by s 6(6)(c) of the same Constitution. See Nwabueze RN "Securing widows' sepulchral rights through the Nigerian Constitution" 2010 *HHRJ* 148.

89 *Registered Trustees of the Socio-Economic Rights and Accountability Project (SERAP) v Nigeria* (2009) AHRLR 331.

90 The Court was set up as the legal organ of ECOWAS. Its role is to ensure observance of law and equity in member states especially with regards to the ECOWAS treaty. See mandate and jurisdiction of court http://prod.courtecowas.org/mandate-and-jurisdiction-2/ (Date of use: 26 July 2019).

The challenge in Nigeria is not the absence of laws, especially pertaining to patients' rights and knowledge by healthcare workers, but rather, the enforcement of laws.[91] The laws exist not as one single document, although there are attempts by the Consumer Protection Council (hereafter "CPC") to propose a Patient's Bill of Rights[92] which will be a codification of all laws protecting patients' rights in Nigeria. Yet, the individual laws as they currently exist have separate sets of ramifications. As mentioned above, without proper enforcement thereof, laws are only words with little or no practical effect in patient and healthcare practitioner engagement.

This research posits that Nigeria has a lot to learn from the comparative analysis, particularly concerning the protection of patients through professional ethics and discipline, health insurance for all, and professional indemnity to cover for damages by healthcare workers, especially where they cannot afford the cost orders awarded by a court of law.

In the case of *Medical and Dental Practitioners Tribunal v Dr John E.N Okonkwo*,[93] the Nigerian Supreme Court accentuated the right of a patient to refusal of treatment, a right stemming from his/her right to freedom of thought, conscience and religion, which is guaranteed in the Nigerian Constitution and provided for in the Code of Medical Ethics in Nigeria. This right to refusal of treatment is to be protected even when it may lead to the end of the life of such patient.[94] Other similar cases like *Akintade v MDPT*[95] and *Dr Rom Okekearu v Danjuma Tanko*[96] also emphasize the alignment of courts in Nigeria with the need for patients' rights protection. These cases are discussed in chapter three 3 of this work.

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91 Iloh GUP *et al* "Patients' rights in an undeserved Nigerian environment: A cross-sectional study of attitude and practice orientation of medical professionals in Abia State" 2017 *BLDE University Journal of Health Sciences* 97-103.

92 In the course of completing this research, the proposed Bill (soft law) was launched by the Consumer Protection Council (renamed Federal Competition and Consumer Protection Council) and the Federal Ministry of Health. It did not go through the legislative procedure of law making as it was passed as soft law and most of its provisions were derived from existing laws.

93 Sections 34 and 35 of the Nigerian Constitution 1979, were retained in sections 37 and 38 of the Nigerian Constitution 1999.

94 *Medical and Dental Practitioners Disciplinary Tribunal v Dr John E. N Okonkwo* (2001) 7 NWLR.

95 *Akintade v Chairman, Medical and Dental Practitioners Disciplinary Tribunal* [2005] 9 NWLR 338 -361.

96 (2002) SC 73.

The Patients' Bill of Rights[97] was launched in Nigeria in 2018 by the Federal Competition and Consumer Protection Council (hereafter "FCCPC"). It enumerates the expectations of a patient from any health facility (s)he is registered with for treatment. Twelve rights are provided for in this bill including the right to privacy; the right to a clean environment; the right to information in the medium the patient understands; the right to be treated with respect; the right to visitation within regulations conducive for healthcare; the right to decline care; the right to complain; the right to receive urgent intervention in case of emergency; the right to quality care; the right to transparent billing, and the right to timely access to medical records. The bill is an aggregation of rights from other legal instruments.[98]

1.4.3 Patients' rights in South Africa

The Constitution of the Republic of South Africa, 1996 (hereafter "Constitution RSA") protects patients' rights directly and indirectly.[99] South Africa also has a document dedicated specifically to patients' rights, which is in alignment with the Constitution. The National Patients' Rights Charter of South Africa (hereafter "SA Charter") outlines the rights of patients in the country and these rights serve as a guide for both patients and healthcare workers as well as set out the responsibilities of patients.[100]

The Health Professions Act 56 of 1974 established a statutory body, namely the Health Professions Council of South Africa (hereafter "HPSCA"), which sets professional and ethical standards for healthcare professions with the aim of protecting the public and guiding the professions.[101] Some of the rights of patients set out by the SA Charter also includes the right to a healthy and safe environment;[102] the right to participate in healthcare decision making; the right to access healthcare services; the right to knowledge of one's medical aid scheme or health insurance; the right to choose a

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97 An aggregation of patients' rights that exist in other instruments including the Nigerian Constitution, the Consumer Protection Act, the Child Rights Act, the Freedom of Information Act, the National Health Act.

98 Hashim Z "Patients' bill of rights: Making health a human right in Nigeria" https://www.premiumtimesng.com/news/headlines/325291-patients-bill-of-rights-making-health-a-human-right-in-nigeria.html (Date of use: 14 June 2019).

99 Constitution RSA chapter 2.

100 http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_ rules/booklet_3.pdf (Date of use: 6 June 2018).

101 www.hspca.co.za (Date of use: 28th May 2018).

102 HPCSA Guidelines for Good Practice in the Healthcare Professions; National Patients' Rights Charter s 2.1.

healthcare service provider; the right to know the person who is providing healthcare; the right to confidentiality and privacy except disclosure with informed consent or by an order of court; and the right to informed consent detailing full and accurate information on the nature, treatment, risks, and cost of treatment. A patient also has a right to refuse treatment where it does not affect the health of others, a right to be referred for a second opinion, a right to continuity of care forbidding abandonment without referral or being handed over, and a right to make complaints about healthcare services with an investigation and response to such investigation.[103]

The SA Charter includes the responsibilities of patients, clearly identifying that patients have a duty to themselves to take care of their own health, care for and protect their environment, respect the rights of other patients and healthcare providers, and utilize the healthcare system properly and not abuse it; this is a distinguishing factor from patients' rights provisions in Nigeria. Other responsibilities of patients in the SA Charter include knowing local health services, providing accurate information to healthcare providers, advising healthcare providers of their wishes with regards to their deaths, and complying with treatment or rehabilitation procedures. Patients under the SA Charter also have a duty to enquire about the cost of treatment and rehabilitation and arrange payment, as well as take care of health records in their possession.[104]

The practical effect of the SA Charter is that while a professional may be held liable where (s)he breaches one of the rights of a patient, a patient cannot be held liable for not fulfilling his/her responsibilities as provided for in the SA Charter. The only obvious benefit of the patient responsibilities clause is that doctors can use refusals as a defence in a clinical negligence claim or in a claim where a patient state that his/her rights have been infringed but (s)he has not fulfilled his/her own responsibility. The SA Charter identifies the right to health as a fundamental right but expands on the right to health provided for in the Constitution RSA.[105]

The National Health Act 61 of 2003 (hereafter "SA NHA") and cases which have been decided in South African courts have also shown that the country's legal system

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103 SA Charter 2.2. https://www.westerncape.gov.za/text/2003/patients_rights_charter. pdf (Date of use: 14 June 2019).

104 SA Charter 3.1-3.10.

105 Constitution RSA s 27.

promotes the rights of patients.[106] It is yet to be seen whether patients know enough about their rights and can challenge a possible infringement of such right and obtain remedy in some circumstances. There is a challenge with state-funded healthcare and rationing of health resources in cases where the state healthcare system, which provides healthcare for the majority, is the culprit. In such cases, patients, who only want to get well, may not be enthusiastic about pursuing their rights, as they are at the mercy of the doctors, nurses and healthcare workers, thus their rights are not their first concern. This research calls for an international framework for a patients' rights law which can enforce state liability and provide for the payment of damages. This will be a beneficial law in South Africa and across the world for the promotion of patients' rights, especially where the governments of countries are guilty of violating same.

The case of *Soobramoney*[107] highlights one of the ways by which a patient might want to assert his/her rights. In this case, Mr. Soobramoney wanted the court to compel the Kwazulu-Natal Department of Health to provide him with dialysis though he was not a candidate for a transplant. He initially won in his request for an interdict, but later lost in the Constitutional Court. His plea was on incorrect grounds, namely claiming a right to emergency medical treatment. The Constitutional Court, however, stated that the State could only provide services within its ability. He died shortly after. In other cases, the courts have enforced the rights of patients to prevent infringement or granted relief where the abuse had already taken place.[108] A detailed evaluation of patients' rights in South Africa is discussed in chapter four of this thesis.

1.5 Patients' rights and human rights

The codification of patients' rights is grounded in a human rights approach.[109] Patients are persons who use health services either for wellness consultation or curative reasons. The services range from prevention, treatment, and management of illness to the preservation of physical and mental well-being. The human rights of these patients are not suspended when they are at the health facilities. In those cases where

106 See *Minister of Safety and Security v Xaba* 2003 (2) SA 703 (D); *S v Makwanyane* 1995 (3) SA 391 (CC) 506, 507.

107 *Soobramoney v Minister of Health; Kwazulu-Natal* 1998 (1) SA 765 (CC).

108 See for example *Palmer v Palmer* 1955 (3) SA 56 (O); *Stoffberg v Elliot* 1923 CPD 148; *Jansen van Vuuren and Another; NNO v Kruger* 1993 (4) SA 842 (A).

109 https://www.opensocietyfoundations.org/uploads/c3d9b48d-a714-4a68-8351-b2919970c79e/practitioner-guide-kyrgyzstan-en-20150428_1.pdf (Date of use: 14 June 2019).

patients are rendered incapable of making decisions on their own due to mental or other ill health, human rights tailored to their needs and categorized as patients' rights protect them from abuse in their vulnerable states.[110] In summary, patients' rights are an adaptation and/or modification of human rights for users of health services.[111] To buttress this, certain selected rights, which are generally accepted as human rights, may be asserted by patients in relation to their healthcare too, some of which have been examined above.

1.6 Distinguishing patients' rights from other rights

Rights can be distinguished based on the persons or things on which they are bestowed, or the power acquired through such rights, and how the beneficiaries can get reprieve or relief when the rights are ignored or infringed upon. There are natural and legal rights, negative and positive rights, claim and liberty rights, individual and group rights, among other classes of rights. There also exist human rights, animal rights, patients' rights, children's rights, women's rights and other such forms of rights that concern groups or individuals.

Patients' rights are characterized by the subservient position in which patients find themselves. This position of weakness requires that certain rights be bestowed upon them in the doctor-patient relationship. These rights should function alongside other fundamental rights. It is therefore pertinent to highlight the justification for a demand that the rights of patients be established as a distinct class of rights. The imbalance of power in healthcare settings suggests the need for the ultimate protection of the patient to be able to prevent practitioner-centred care and ensure patient-centred care.

1.6.1 Ethics and patients' rights

Ethics concerns the way in which we relate to one another, and with medico-legal dilemmas, the healthcare practitioner is torn between how to solve problems and, in turn, protect the rights of patients. Applied ethics is of great relevance to healthcare practitioners. They are faced with day-to-day incidences when they must use their

110 https://www.who.int/genomics/public/patientrights/en/ (Date of use: 14 June 2019).
111 https://www.hhrguide.org/2014/02/20/testing-page-1/ (Date of use: 14 June 2019).

discretion and where they must make swift decisions which may lead either to assert the right of a patient or to abuse it.[112]

Ethical theories on decision making can follow the rights approach, a utilitarian approach, fairness, common good, virtue, values or an existential approach. However, the four major ethical pillars in a healthcare context as enunciated by Beauchamp and Childress are autonomy, beneficence, non-maleficence, and justice.[113] These ethical principles guide courts and healthcare workers in their administration of healthcare to users of their service.[114] Although this research advocates for patient-centred care as opposed to practitioner-centred care, there is a school of thought which suggests that the best interests of a patient might require a paternalistic approach where the healthcare practitioner, who is seemingly more knowledgeable, is left to determine what is best for the patient irrespective of the ethical leaning.[115]

1.6.2 Trust and power in healthcare settings

The question is whether the abuse of patients' rights influences the trust that patients have in their healthcare practitioners to give them quality care. It has been discovered by most polls that despite increasing claims for medical malpractice and infringement of patients' rights, there is still a strong belief in healthcare workers and patients' trust may not actually be in real decline.[116] It is, however, popular opinion as suggested by Dhai and McQuoid-Mason that abiding by the ethics of the profession "will ensure an enhanced relationship of trust between practitioners, their patients, and their colleagues."[117]

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112 Buka P *Patients' rights, law and ethics for nurses* 2nd ed (CRC Press United States 2014) 30.

113 Beauchamp TL and Childress JF *Principles of Biomedical Ethics* 7th ed (Oxford University Press Oxford 2012) 57, 114, 166, 226.

114 See for example *Simms v Simms* [2003] 1 ALL ER 669, *St George's Healthcare NHS Trust v S* [1998] 3 ALL ER 673.

115 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582*; Bolitho v City and Hackney Health Authority* [1998] AC 232.

116 https://www.ipsos.com/sites/default/files/ct/news/documents/2017-11/trust-in-professions-veracity-index-2017-slides.pdf (Date of use: 21 May 2018). Doctors are still in the top five of the most trusted professions in the UK, according to a research study, where about one thousand (1000) participants in an Ipsos MORI Poll on trust in professions participated. The participants believed doctors would tell the truth and the only profession that is believed to be more trustworthy is the Nursing Profession. Nurses top the chart. This show there may not really be a decline of trust in healthcare settings as the two most trusted are in the healthcare professions. Noteworthy is the relative consistency of results of this poll from 1983, especially on doctors.

117 Dhai A and McQuoid-Mason DJ (eds) *Bioethics, human rights and health law: Principles and practice* (Juta Cape Town 2017) 33.

1.6.3 Solving the complex problem of rights in healthcare settings

> As a material interest so heavily influenced by economic and social determinants, by the availability and constraints of scientific and cultural knowledge, and by background protections of property and contract rights, the right to health presents momentous legal challenges.[118]

The above quote underscores the complexity of the right to health discourse and how challenging it can be; however, its complications cannot erase the need for a solution-based approach to the intricacies of rights discourse. This research intends to promote the codification of a single patients' rights document which harmonizes local and regional laws with provisions on patients' rights, juxtaposing international conventions with country-specific laws which make the infringement of such rights actionable and not mere soft law.

The expectation is that by protecting rights of patients, patients and healthcare workers will jointly achieve the UN Sustainable Development Plan goal (hereafter "SDG") three (3), which is to ensure healthy lives and promote wellbeing for all at all ages.[119] Essentially, whether as proponent or antagonist, it is important that the patient is first seen as an individual with rights,[120] then as an individual in special circumstances. The firm arm of the law must be seen to protect the patient in his/her vulnerable state, punish the abuser and cushion the effect of damage occasioned by the abuse of the rights of patients whether by the state, healthcare facility, or an individual healthcare practitioner.

1.6.4 Economics, patients' rights and rationing

A right to health is a fundamental right in the international human rights framework and there is an obligation by states to devote maximum available resources to the right to health.[121] Dhai and McQuoid-Mason are of the opinion that the HPCSA's ethical guidelines are aspirational considering the availability of resources in South Africa and

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118 Young KG "Securing health through rights" in Pogge T, Rimmer M and Rubenstein K (eds) *Incentives for global public health: Patent law and access to essential medicines* (Cambridge University Press United Kingdom 2010) 357.

119 https://www.un.org/sustainabledevelopment/health/ (Date of use: 21 May 2018).

120 Richards DP "The Patient as a person" https://blogs.bmj.com/bmj/2018/02/14/dawn-p-richards-the-patient-as-a-person/ (Date of use: 21 May 2018).

121 Article 2, 12 of the International Covenant on Economic, Social and Cultural Rights http://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf (Date of use: 29 May 2018).

most developing countries.[122] The courts in the UK have been careful to make broad decisions on scarce resources as a justification for an allegation of negligence. In the case of *Knight v. Home Office*,[123] a mentally ill prisoner was not put on continuous watch and he subsequently hung himself. The Court, per Pill J, held that the limited resources meant that the hospital wing of the Brixton prison did not have enough resources and would not be expected to have the same standard of care as a specialist psychiatric hospital.[124] This was, however, not the case in *Bull v. Devon AHA*,[125] *Garcia v. St Mary's*[126] and *Brooks v. Home Office*,[127] where the courts held that financial limitations or scarce resources should not be an excuse for not meeting the minimum standard of care expected in a healthcare facility.

The UK's decisions, as lofty as they seem, may be inapplicable in Nigeria and South Africa, as underdevelopment transcends healthcare to other spheres of governance and might affect the realization of standards in healthcare, except with private healthcare and medical aid.[128] The courts are quick to align with the state's position on scarce resources, not considering the wasteful spending of governments, neglect of health, and the patient.[129]

Financial resources and determining how they can be allocated are subjects of strong debate. It is difficult for governments and healthcare practitioners to utilize existing resources for the myriad of patients with their individual requests and challenges. It is believed that although needs will outweigh resources, the determinants of rationing standards should be protection of the right to life and other patients' rights. Formulators and implementers of rationing decisions must save lives and protect patients' rights to access healthcare.[130]

1.6.5 Patient responsibilities

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122 Dhai and McQuoid-Mason *Bioethics* 33.
123 [1990] 3 All ER 237.
124 Jackson E *Medical law: Text, cases and materials* 4th ed (Oxford University Press United Kingdom 2010) 120.
125 [1993] 4 Med LR 117 (CA).
126 [2006] EWHC 2314 QB.
127 [2006] EWHC 2314 (QB), [1999] 2 FLR 33 (QBD).
128 Dhai and McQuoid-Mason *Bioethics* 33.
129 Pieterse M "The potential of socio-economic rights litigation for the achievement of social justice, considering the example of access to medical care in South African prisons" 2006 *JAL* 125-126.
130 Pieterse 2006 *JAL* 131-133.

The SA NHA highlights certain duties of health users which include adherence to the rules of health establishments, providing accurate information, cooperation when using the health service, treating the healthcare workers and providers with respect and signing a release of liability if they do not accept the treatment recommended by the practitioner.[131] These duties are also to be read along with some of the patient responsibilities of the SA Charter.

The NHS Constitution of the UK also stipulates certain responsibilities for patients. Some of which include taking responsibility for their health, providing accurate information, registering with a general practitioner, keeping appointments, following the course of treatment, participating in public health programs, giving advanced directives on organ donation and giving feedback on care and treatment whether positive or negative.[132]

The Nigerian patient does not have any clearly stated responsibilities apart from those identified in the hospital codes which state their rights and duties or those denoted by specific regional or local medical professional associations.[133] The Nigerian FCCPC's newly promoted Patients' Bill of Rights however includes a number of patient responsibilities similar to those contained in the SA Charter, but it is yet to be seen how it will be accepted by the populace and enforced.[134]

1.7 Problem statement

The concept of rights can be vague and amorphous, hence making the claim to rights a challenge. The importance of patients' rights cannot be overemphasized because patients are a vulnerable class who ought to be protected. Determining the limits of rights and the problem of enforcement of rights is not an easy task, especially considering that healthcare workers and practitioners have limited time and resources in making medical decisions.

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131 SA NHA s 19.

132 NHS Constitution for England 2015 Crown 11 https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england (Date of use: 29 May 2018).

133 University College Hospital Ibadan, one of the foremost hospitals in West Africa, has a patients' rights and responsibility page on its website, https://uch-ibadan.org.ng/content/patients-rights-and-responsibilities (Date of use: 29 May 2018).

134 Ezeamalu B "Consumer council seeks to enforce patients' rights in Nigerian hospitals" https://www.premiumtimesng.com/news/more-news/251258-consumer-council-seeks-enforce-patients-rights-nigerian-hospitals.html (Date of use: 29 May 2018).

Comparing the rights base of patients in Nigeria, South Africa and the UK poses a challenge because of the differences in legal structure. Although these countries have a shared Common Law ancestry, the development of law and pace of development is, in general, different.

The countries in the context of this study have certain provisions of law protecting the rights of humans and, by extension, patients, but the enforcement of patients' rights especially poses a major challenge because of the elusive nature of the right to health, which in most cases cannot be guaranteed. The problem lies in the identification of the scope of rights of a patient, enforcing that right, and remedying the right appropriately where there has been an infringement. Although charters, hospital policies and ethical guidelines exist on patients' rights in countries around the world, the lack of a uniform or globally accepted set of rules like the UDHR, has consistently put patients in dire straits. This makes rights infringements commonplace in countries all over the world, thereby necessitating a call for the recognition and defence of their rights.

1.7.1 Premise

Patients' rights are often classified as human rights or under the general category of rights. I argue that this should not be the case, as the rights peculiar to patients should take into consideration their vulnerability and conditions which limit their powers and capacity to defend their rights. Patients' rights have either been promoted by hospitals, healthcare workers associations or professional medical bodies; however, the concept of patients' rights transcends professional self-regulation to promoting law in the defence of the weak and helpless.

The premise is that whereas laws exist that promote or protect patients' rights as part of a general body of laws in the Constitutions of Nigeria and South Africa, some laws in the UK, as well as soft laws such as the Code of Medical Ethics of Nigeria, the SA Charter and the NHS Constitution of the UK, patients' rights are still being abused. This is either as a result of an uninformed society, weak enforcement mechanism where there is an infringement of these rights, or a system that favours the healthcare worker and facility. A clear focus on the rights of patients, strict enforcement by local laws and an international framework to support it will make individuals, healthcare workers and institutions, as well as governments identify the gravity of the rights of patients and protect these rights.

1.7.2 A problem worthy of research

It is noteworthy that upholding patients' rights influences patient care and achieves the third SDG of the UN.[135] According to the UN rapporteur on health, although the right to health is not defined as a human right, it is enshrined in the international human rights framework as a fundamental right.[136] The infringement on the right of patients has led to loss of lives and limbs, and is one of the leading causes of death around the world.[137] Costs paid to remedy medical errors which are as a result of the violation of patients' rights are also a remarkable part of the world's resources.[138]

1.8 Research question

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135 The UN's Sustainable Development Goals replace the Millennium Development Goals as tools of measurement for global development. https://www.un.org/sustainabledevelopment/health/ (Date of use: 15 May 2018).

136 http://www.ifhhro.org/news/the-right-to-health-and-the-sustainable-development-goals/ (Date of use: 15 May 2018).

137 Makary MA and Daniel M "Medical error: The third leading cause of death in the US" https://www.bmj.com/content/353/bmj.i2139 (Date of use: 28th May 2018); McMains V "John Hopkins study suggests medical errors are third-leading cause of death in US" https://hub.jhu.edu/2016/05/03/medical-errors-third-leading-cause-of-death/ (Date of use: 28 May 2018).

138 Medical negligence payments in England in the year 2017 totalled about 1.6 million pounds rising to about 60 billion pounds for settling future claims of two years, rising about four-fold in the last decade. See House of Commons Committee on Public Accounts, the Fifth report of session 2017-2019 HC 397 https://publications.parliament.uk/pa/cm201719/cmselect/cmpubacc/397/397.pdf 4 (Date of use: 28 May 2018), also Wilde C, Lynch P and Belcher A "Cost legacy of decades-old NHS blunders begins to rise" https://www.bbc.com/news/uk-england-42442343 (Date of use: 24 May 2018), Vize R "Cost of NHS negligence claims soars as staff fear speaking out on safety" https://www.theguardian.com/healthcare-network/2017/dec/01/nhs-negligence-claims-soars-staff-fear-speaking-out-on-safety (Date of use: 24 May 2018).

The research question is whether there is a difference or similarity in the rights of patients in Nigeria, South Africa and the UK. The selection of these countries is based on the fact that Nigeria and South Africa have a common law history originating from England. Though the shared history would suggest some similarities, there are however also major differences having an impact on the lives of patients in these countries. I also ask whether there should be a globally accepted uniform law on patients' rights which will serve as a yardstick for countries around the world.

The following sub questions are also investigated:

i. What are rights?
ii. What are patients' rights?
iii. Should patients have a special or different category of rights or should patients' rights be generally classified as human rights?
iv. Are there any differences between the rights of patients in Nigeria, South Africa and the UK?
v. Are there laws specifically guiding the rights of patients in Nigeria, South Africa and the UK and if there are, what are the enforcement mechanisms to ensure the protection of such rights, or the remedying of the rights where they are infringed upon?
vi. Will the existence of a global health law protecting rights of patients and an enforcement mechanism ensure the right to health, patient safety and the highest attainable standard of living?

1.9 Hypothesis and presumptions

1.9.1 Hypothesis

The absence of a global patients' rights law makes it difficult to universalize and enforce patients' rights. A comparison of patients' rights in Nigeria, South Africa and the UK will identify gaps and lessons for the countries, thereby improving healthcare jurisprudence in these countries and around the world.

1.9.2 Presumptions

i. Patients' rights ought to be protected whenever and wherever. There are cases of regular infringement of the rights of patients in different parts of the world.
ii. Albert Dicey suggests that one of law's greatest objectives is the regulation of human conduct in the society.[139] The emphasis on the protection of patients is to acknowledge their vulnerable state and ensure that the law protects the weak in society; hence patients' rights are not merely human rights.
iii. There are soft laws like the Patients' Rights Bill (Nigeria), the SA Charter, the NHS Constitution of the UK and International Codes on Human Rights in relation to patients, which serve as moral guidelines for healthcare providers and patients. These have helped protect the rights of patients, but should not remain mere moral codes, but laws with consequences and punishment of their own.
iv. The NHS Constitution may serve as a good guide for a global law on patients' rights if placed side by side with the SA Charter. A juxtaposition of the laws of the countries in this thesis will shed light on the best possible ways of managing the rights of patients and pave the way for a unification of laws for a global law on patients' rights.

1.10 Research aims

The aims of the study are to:

i. investigate the origin of patients' rights as a branch of human rights/class of rights.
ii. investigate what the scope of patients' rights is.
iii. ascertain whether patients deserve a special class of rights or if they should be catered for under the broad spectrum of human rights.
iv. investigate and ascertain the existence of patients' rights and the protection of such rights by law in Nigeria, South Africa and the UK.

139 Buka *Patients' rights law* 6.

v. evaluate the effect of patients' rights law on healthcare and trust in healthcare settings.
vi. assess the practicability of the concept of a right to health as protected by law.
vii. identify gaps and lessons for the countries compared from the comparative analysis and suggest reviews for the countries to enhance global patient rights protection.
viii. suggest the codification of a globally acceptable patients' rights law through harmonization of regional and national laws which will serve as a guide for countries on the protection of patients' rights.
ix. explore international means of seeking redress or remedying patients' rights in international or regional courts.

1.11 Research methodology

The primary research method for this thesis will be that of a literature study.

The Nigerian Constitution, Constitution RSA and NHS Constitution of the UK will be consulted. Other Acts of parliament and professional regulatory frameworks in the countries being compared will also be considered.

A comparative analysis of case law on patients' rights in the countries in this research context will also be done. A comparison will be done on the effect of the laws protecting patients in Nigeria, South Africa, and the UK as well as the enforcement mechanism for the assertion of these rights. This analysis will also include decisions by the professional ethics and disciplinary bodies where patients' rights were deemed to have been infringed upon in each of the compared countries, to confirm consistencies, departures, and variance in some of the practices and decisions.[140]

The international framework for patients' rights protection will be consulted, as there are established regional frameworks accepted in Africa, Europe, and America. The research will utilize already existing and published data and analytics on patients'

[140] Medical and Dental Practitioners Tribunal Nigeria, Health Professions Council of South Africa and the Fitness to Practice Panel of the General Medical Council, UK.

rights in the countries being compared as well as where necessary, other countries in the world.

1.12 Framework of the thesis

CHAPTER 1: INTRODUCTION

This chapter is an introductory chapter explaining the terms “patient”, “rights” and “patients’ rights”. It also poses the research questions and delineates the hypothesis.

CHAPTER 2: RIGHTS: HUMAN RIGHTS VIS-À-VIS PATIENT’S RIGHTS

This chapter analyses the term “rights”. It discusses the evolution of rights, the distinction between certain rights and considers the concept of human rights. It is asserted in this chapter that although patients’ rights are human rights, they are a distinct category of rights which require special protection.

CHAPTER 3: PATIENTS’ RIGHTS IN NIGERIA: THE DEARTH OF LAW AND ENFORCEMENT

This chapter assesses the rights of patients in Nigeria. These rights are protected by the Nigerian Constitution, the NHA Nigeria, Patients’ Rights Bill and other similar legislative provisions in Nigeria. The existence of patients’ rights in Nigeria from the provision of legislations and defended by case law is identified. This chapter posits that the numerous laws protecting patients’ rights in Nigeria do not necessarily translate to the protection of patients, as the mechanisms for protecting the rights of patients are insufficient or inadequate. The chapter concludes by highlighting the need for the timely promotion and enforcement of the Patients’ Bill of Rights by the CPC (which was later renamed the FCCPC) and the Federal Ministry of Health.

CHAPTER 4: PATIENTS’ RIGHTS IN SOUTH AFRICA: A MULTI-SYSTEM APPROACH AND A RIGHT BASED SOCIETY/STATE FUNDED HEALTHCARE

Chapter 4 evaluates the rights of patients in South Africa. The Constitutional provisions which are beneficial to patients are analysed; and the sections of the SA NHA, the Mental Healthcare Act 17 of 2002 (hereafter “MHCA”) and the SA Charter which protects the rights of patients are identified. The chapter delves into the rights of two categories of patients, namely, mental healthcare patients and persons living with HIV and AIDS, to facilitate discussion on patients’ rights. The role of the courts and

professional organizations such as the HPCSA in protecting the rights of patients in South Africa are also highlighted. This chapter concludes by recommending the significant regulatory framework for traditional health practices in South Africa, as a pilot legal framework for African countries where many residents are patients of traditional healers.

CHAPTER 5: PATIENTS' RIGHTS IN THE UNITED KINGDOM: THE NHS APPROACH

This chapter analyses the rights of patients in the UK using the NHS Constitution as the benchmark for assessment. It discusses the rights protected by the NHS Constitution and the mechanisms established to protect these rights. This chapter assesses court decisions in the UK and attempts to emphasize the rights of patients. This chapter discovers that the NHS approach is challenged by lack of resources for continued free healthcare services, and increased privatisation of the NHS. There is also an increasing number of private healthcare facilities and patients, which requires increased regulation and protection.

CHAPTER 6: A COMPARATIVE ANALYSIS OF PATIENTS' RIGHTS IN NIGERIA, SOUTH AFRICAN, AND THE UNITED KINGDOM

This chapter is a comparative analysis of the patients' rights models of countries within the scope of the research. The comparison is based on their legal frameworks, case law and their enforcement mechanisms. Similarities between the countries, the major differences and lessons to learn from each jurisdiction are identified. The major similarity discussed in this chapter is the existence of some legal framework and an attempt to protect patients' rights. There is however a varying degree of demand for these rights and its protection by the courts and other state agencies. Differences in the models include expanding patients' rights protection to traditional healthcare services in South Africa among others.

CHAPTER 7: PATIENTS' RIGHTS AND GLOBAL BEST PRACTICES

Chapter 7 considers various international instruments which protect patients' rights and existing legal frameworks around the world. A juxtaposing is attempted with the existing legal framework as a means of determining a gauge against which to measure

patients' rights protection and infringement across the globe. This chapter considers global best practices in patients' rights and laws that protect patients directly or remotely. In this chapter a draft global law for the protection of patients' rights is proposed. This law is a hybrid of the NHS Constitution, SA NHA and Patients' Bill of Rights (Nigeria).

CHAPTER 8: CONCLUSION AND RECOMMENDATIONS

This final chapter reflects on the preceding chapters, highlighting that there are some similarities and divergence in the legal framework for patients' rights in the jurisdictions compared. Against the backdrop of a great deal of patient rights infringement which requires global attention, the argument is drawn to a close with the recommendation of a global patients' rights law which countries must be signatories to. This is to ensure equality and quality healthcare around the world and the attainment of the SDG 5. This chapter makes other recommendations which may be adopted for the promotion and protection of patients' rights explaining how utilising the recommendations will be for improved patients' rights.

CHAPTER 2: RIGHTS: HUMAN RIGHTS VIS-À-VIS PATIENTS' RIGHTS

2.1 Introduction

The concept of rights has stirred debates amongst scholars and laymen alike, especially regarding the role of rights in healthcare.[141] The debates have evolved around the universality of rights, protection of rights, and the varying types and classes of rights.[142] The slant in classification and enforcement of the rights of a patient are pivotal to this research, with the chief aim of arguing that there is a need to de-classify patients' rights from the hitherto subjugation under the general umbrella of human rights. This is because the patients are in a more vulnerable state than the average human being, and such patients' recovery to enjoy the human rights in full, is dependent on the quality of healthcare received from the medical practitioners. In this chapter therefore, I attempt an extensive historical appraisal of rights in general, and the classification of human rights.

In order to guide towards the attainment of the aims of this research, some schools of thought on rights, some of the types of rights, and how rights in general may affect the rights of a patient are examined. The chapter in no way tries to exhaust the debate on rights. It only serves as an overture to the real topic of the research, which is patients' rights. I therefore evaluate patients' rights from a human rights perspective. I, however, argue in this chapter as buttressed in the subsequent chapters, that there is the existence of patients' rights as a distinct class of rights from general human rights.[143] A patient is human and has both human and patients' rights which must be protected. This is because being a patient means that the person is more vulnerable and should enjoy increased protection.

In a bid to better structure the arguments in this chapter, as well as facilitate the discussion on rights and human rights; and mark out the importance of patients'

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141 Pieterse M "Can Rights Cure? The impact of human rights litigation on South Africa's health system" 2014 *PULP* 2.

142 Olomojobi Y *Medical and health Law The right to health* (Princeton and Associates Publishing Co 2019) 4.

143 Peled-Raz M "Human rights in patient care and public health: a common ground" https://publichealthreviews.biomedcentral.com/track/pdf/10.1186/s40985-017-0075-2 (Date of use: 15 June 2019).

rights as a distinct class of rights, I start this chapter with the various definitions of rights and then consider the evolution of rights. Under the evolution of rights, I consider natural rights and legal rights. Under legal rights, I discuss the Cyrus Cylinder and Code of Hammurabi; the Magna Carta (1215); the Petition of Right (1628); the United States Declaration of Independence (1776); the Constitution of the United States of America (1787); the Declaration of the Rights of Man and of the Citizen (1789); United States Bill of Rights (1791); First Geneva Convention (1864); the United Nations (1945); the Universal Declaration of Human Rights (1948) and the Human Rights Covenants. I thereafter consider human rights and further declassify human rights into civil and political rights, economic, social and cultural rights. Finally, I examine human rights in the three jurisdictions in this research, namely South Africa, Nigeria and the UK.

This chapter further concretizes the argument of this research, which is that patients are in a state of vulnerability that requires deeper thoughts at ensuring that they are treated fairly and thoughtfully, as they deserve. Patients' rights should therefore be accorded a status of global recognition and attention distinct from the general human rights. I am not opining that the rights of patients have been totally neglected, but stating that catering for patients' rights under the purview of human rights generally is not sufficient, especially considering that patients assume the role of dependents when they submit to medical care,[144] and that the implications should a breach of their rights occur, are severe. This chapter therefore further amplifies the notion that creating separate and distinct protection documents and laws for the protection of the patient is an absolute necessity.

2.2 Rights: A jurisprudential thought

A right means that which a person has a just or valid claim to, be it land, a thing or the privilege of either doing or saying something. It refers to an entitlement which can be asserted. It is an interest recognized and protected by the law; respect for that which is a duty and disregard of that which is a wrong.[145] The

144 Nevhutalu HK *Patient's rights in South Africa's public health system: moral-critical perspectives* (PhD Dissertation University of Stellenbosch 2016)1-2.

145 Bird R (ed) *Osborn's concise law dictionary* 7th ed (Sweet and Maxwell London 1983) 293.

definition of rights has been expounded from different perspectives by many authors. Two prominent schools are the interest and choice theorists. The interest theorists[146] opine that a person has a right when others owe him/her the duty to protect his/her interests, hence, they associate human relations with rights. The choice theorists,[147] consider rights as the power to choose to do or not to do something, but this view has been countered because some rights impose obligations which cannot be waived.

Rights are also considered by some scholars to be derivable from permissible or impermissible actions based on the ethical or moral philosophies of different societies and codified as law, to be enforced by institutions or governments.[148] The UDHR Preamble states that the

> … recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world...[149]

In the past, the political system in place in a nation or settlement dictated how rights were apportioned to persons as permitted by their position in the social hierarchy. In the present times positive rights[150] emanate from legislation and international declarations; they are built on the notions of equality and liberty. Additionally, the meaning of rights may be historically deduced from what is called the "Four Freedoms",[151] which are freedom of speech, freedom of worship, freedom from want and freedom from fear.[152] In order to better understand rights, there is a need to consider the evolution of rights over the years and theories on

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146 See Lyons D *Rights, Welfare, and Mill's Moral Theory* (Oxford University Press United Kingdom 1994) 41.

147 See Hart HLA *Essays on Bentham: studies in jurisprudence and political philosophy* (Clarendon Press Michigan1982).

148 Stelzig 1998 *University of Pennsylvania Law Review* 901-904.

149 https://www.humanrights.com/what-are-human-rights/universal-declaration-of-human-rights/ preamble.html (Date of use: 3 January 2019).

150 There are essentially two types of rights: the positive rights which is manmade rights and is therefore a given, and the negative right which is the natural rights. Negative rights impose a negative duty on others; that is a duty to do nothing and not interfere. Positive rights on the other hand require others to act in a certain way to bestow such a right. See generally https://www.liberalistine.org/knowledge/positive-and-negative-rights/ (Date of use: 2 October 2019).

151 The Four Freedoms were posited by United States President Franklin D. Roosevelt in his State of the Union Address (the four freedoms speech) on Monday, January 6, 1941. This he termed as the four essentials of human freedoms. See generally https://www.ourdocuments.gov/doc.php?flash=false&doc=70 (Date of use 2 October 2019).

152 https://www.fdrlibrary.org/hu/four-freedoms (Date of use: 3 October 2019).

rights. Natural rights and human rights will therefore be my first attempt at a historical appraisal of rights, as is contained below.

2.3 Evolution of rights

2.3.1 The natural rights theory

Rights as is applicable today, is a product of evolution across several centuries. Before there was any clear delineation as to what rights are, the prevalent practice was natural law on the premise of religion. The term, “natural law” was a coinage by Sophists in the fifth century. Hitherto, there was no differentiation between law, rights and custom. What came to be known as the natural law was the belief in the ancestral powers and that which is good by nature. This is underscored as the belief in a resistance to the conventional authority and accompanying injustices. This appeal to unwritten laws was, however, increasingly antagonistic. The Sophists therefore adopted nature as a metaphor for natural powers and human laws that the weak adopted, so that they could be protected from the strong; hence the basis of the clamour for equality of all. Plato and Aristotle argued that natural law provides an objective structure of right, justice and good; this definition of the embodiment of natural law was adopted by the Romans. The Stoics furthered the discussion by adding that everyone is an individual under a universal law that was applied to everyone equally.[153] The natural law is therefore derived from man’s internal nature and not an external force.

The natural rights tradition is an offshoot of the classical natural rights theories, while natural rights are offshoots of natural law. Initially, proponents of this school of thought were more focused on duties owed to the state, or society, and to God, than with actual rights.[154] Natural law owes much of its existence to divine law, which underscores the responsibility of the state to maintain freedom of citizens from internal and external threats, and had been the hinge in the social character

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153 Villiers JD *Thinking outside the cage: sacrifice, equality and the plight of the animal* (LLM thesis University of Pretoria 2012) 88-94.

154 D’Entreves AP *Natural law: An introduction to legal philosophy* 2nd ed (London 1970) 4 and Meron T (ed) *Human rights in international law: Legal policy and issues* (Clarendon Press Oxford 1984) 3 cited in Feldman D *Civil Liberties and human rights in England and Wales* 2nd ed (Oxford University Press New York 2002) 21.

of ancient Israel, Athens, Rome and the Netherlands.[155] The absolutist tendencies of the use of divine law, as was exemplified in the 'Divine Rights of Kings' asserted by the Stuart monarchs in the seventeenth century England, particularly in states with established churches, led some liberals to attempt to discover natural laws from the observable state of the world and human behaviour. This is closely related to the thirteenth century concept of natural law embraced by St. Thomas Aquinas and Duns Scotus, recognising the role of human rationality in elucidating divine will.[156] From Jean-Jacques Rousseau's influential view of the eighteenth century, man became the centre of attraction – not the society and not God – although on a moral and intellectual perspective. This perspective sought to protect human rights and freedom from societal interference in the name of social morality. The proposed mode to guarantee this by Rousseau was by laws reflecting the general will of the people and backed by sanction – banishment or death.[157] Although harsh, this became the foundation for the protection of liberties and rights as we have it today.

Secular natural law,[158] however, revealed its fallibility too, in that it can tend towards draconian rule.[159] This was the sure revelation that natural law does not guarantee rights, as it is subject to the will of those who invoke it. In the US and France, natural law, driven with revolutionary objectives, was used to limit governmental powers in the eighteen and nineteenth century. Human rights thereafter became the foundation of post-revolution legislations.[160]

The natural rights theory expounded by John Locke (1632-1704) believed in three natural rights, namely life, liberty, and property. It posited that everyone has the right to live, everyone has the right to do as they wish, provided that it does not breach the right of others to live and everyone has a right to whatever they acquire

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155 Feldman *Civil liberties* 21.

156 Feldman *Civil liberties* 21.

157 Feldman *Civil liberties* 22.

158 Weinreb LL "A secular theory of natural law" 2004 *FLR* 2288.

159 Hobbes T *Du Contract Social (*Book 1) 1 and (Book 2) 3-6 cited in Feldman *Civil liberties* 22.

160 See generally Hobsbawn EJ *The age of revolution 1789-1848* (Sphere Books London 1973) 270, 288; Rude G *The French revolution* (Weidenfeld & Nicolson London 1988) 59-60; Schama S *Citizens* (Viking Penguin, 1989) 746-847; Levy L *Constitutional Opinions Aspects of the Bill of Rights* (Oxford University Press New York 1986) 124-125 all cited in Feldman *Civil liberties* 22.

by gift or trade, if it does not breach the first two rights of others. Locke looped in the social contract theory where individuals trade off some of their rights to the authority in their community in exchange for the protection of their other rights. This suggests that if the government cannot protect these other rights, such failing government ought to be overthrown.[161] The natural rights theory directly protects the rights of patients to life, individual autonomy and consent, and suggests enforceability of socio-economic rights.

2.3.2 Legal rights

Another major class of rights is the legal rights. These are rights which are codified in statutes, articles, declarations or other legal instruments and backed by sanctions or the guarantee of compensation or redress in cases of breach. The implication of this is that legal rights depend on recognition by the state or any other institution with authority through its constitution or courts.[162] They may be passed as legal instruments or excised from decisions of authoritative bodies.[163]

Legal rights impact and are binding on all people subject to the authority which promulgated them, even when these persons are ignorant of their existence. Also, while some legal rights are natural/moral rights which were enacted into law like the right to life, other legal rights were enacted as a fallout of civilization or the demands of the political system, for example, franchise.[164] Most existing patients' rights are legal rights, as they are backed by some statute or legal instrument.

Importantly, human rights, which are the basic rights of humans by virtue of their being "human", have also been enacted into legal or constitutional rights so that the state can enforce them, and individuals or organizations cannot breach them under the guise of ignorance. The court systems are quick to make decisions which align with the legal rights as they are the institutions which interpret these

161 https://plato.stanford.edu/entries/locke-political/ (Date of use: 15 June 2019).
162 See Paine T *The rights of man* (Prometheus Books New York 1987) 46-47.
163 Paine *The rights of man* 47.
164 https://thelawdictionary.org/legal-rights/ (Date of use: 15 June 2019).

rights and their interpretations form judicial precedents, which aids the understanding of various statutory provisions and other legal instruments.

It is noteworthy that while morality says, "do unto others what you want them to do to you", proper actions are relative and subjective from one person to the other, such that "what you want done to you" may not be an ideal measure of what is "proper".[165] There needs to be a standardization of proper behaviour and a formal channel of correcting or fixing the outcomes of negative actions. Having enactments that capture what constitutes a right, how a breach is determined and steps to get redress or compensation, along with a court system to apply the enactments to practical day to day living, ensures a uniform standard of behaviour thereby ensuring a stable system. Such a system will be able to caution, penalise and compensate breaches of human rights impartially as appropriate.[166]

2.3.2.1 The evolution of legal rights

Legal rights have evolved over the centuries, from the Cyrus Cylinder to the UDHR and various human rights treaties and conventions. Tracing rights in history is of importance to this research, as it is the foundation of patients' rights. The idea of patients' rights is indefensible if the theory of rights is not justified. Historically, rights and the protection of rights have been global issues with significant incidences. The significant happenings in its history are highlighted below.

2.3.2.1.1 The Cyrus Cylinder 539 B.C.

The Cyrus Cylinder of 539 B.C. is regarded as one of the earliest charters of human rights. Cyrus the Great and his armies conquered Babylon and freed the slaves with a declaration that all were free to choose their religion. He also promoted the equality of races. The decree by Cyrus is reported to have been recorded in the Akkadian language with cuneiform script on a baked-clay cylinder.[167] The decree is recorded as the world's first charter of human rights. It

165 Velasquez M *et al* "Ethical relativism" https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/ethical-relativism/ (Date of use: 15 June 2019).

166 Fagan A "Human rights" https://www.iep.utm.edu/hum-rts/ (Date of use: 12 February 2019).

167 Slavin B "Cyrus cylinder: reminder of Persian legacy of tolerance" https://www.al-monitor.com/pulse/originals/2013/03/cyrus-cylinder-iran-religious-freedom-minority-rights.html#ixzz5qs3Y4Su7 (Date of use: 15 June 2019).

is translated into the six official languages of the UN[168] and is regarded as constituting the four preceding articles of the UDHR.

2.3.2.1.2 The Magna Carta (1215)

In 1215, the Magna Carta was executed by the King of England, John Lockland. This happened after pressure from the barons who desired that his uncontrolled use of power should be curbed with a charter that dictated the limits of royal authority. Before then, the King seemed to have unfettered power over the subjects.[169] This charter guaranteed the rights of individuals generally, and their rights to justice and to a fair trial. Subsequently, in 1689, the English Bill of Rights,[170] guaranteeing liberties of citizens received royal assent. The Bill codified the procedure for the parliament and provided for the right of all subjects to justice in England. Furthermore, the Bill influenced the proclamation of the United States Bill of Rights of 1789, the UDHR 1948[171] and the European Convention on Human Rights 1950.[172]

2.3.2.1.3 Petition of Right (1628)

The Petition of Right[173] was initiated by Sir Edward Coke and was based on earlier statutes and charters which affirmed four important freedom principles, which include the need for parliamentary consent before any taxes were issued; that no subject/citizen be imprisoned without just cause, in alignment with the right of *habeas corpus*; that no soldiers be quartered upon the citizenry; and that martial law should not be used in peace times.[174] It was produced by the English parliament in 1628 and was passed to King Charles I as a declaration of civil liberties. It was a reaction to the policies of the King which had been unpopular

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168 These are Arabic, Chinese, English, French, Russian and Spanish.

169 Heather W "What is the Magna Carta?" https://www.livescience.com/2458-magna-carta-changed-world.html (Date of use: 3 January 2019).

170 https://www.parliament.uk/about/living-heritage/evolutionofparliament/parliamentaryauthority/_revolution/collections1/collections-glorious-revolution/billofrights/ (Date of use: 10 February 2019).

171 https://www.un.org/en/universal-declaration-human-rights/ (Date of use: 20 April 2019).

172 Formally known as the Convention for the Protection of Human Rights and Fundamental Freedoms signed on 4th November 1950 and effective on the 3rd of September 1953. https://www.echr.coe.int/Documents/Convention_ENG.pdf%23page=9 (Date of use: 23 April 2019).

173 https://www.bl.uk/collection-items/the-petition-of-right (Date of use: 27 July 2019).

174 Foster "Petitions and Petition of Right" 1974 *JBS* 21-45.

and unacceptable, characterized by forced loans, arbitrary arrests, imprisonment and volatility in parliament.

2.3.2.1.4 The Code of Hammurabi (1754)

The Code of Hammurabi[175] on the other hand was a set of rules promulgated by the Babylonian King Hammurabi. The rules in the Code are regarded as the "most complete and extant perfect collection"[176] of Babylonian laws. The Code has two hundred and eighty-two outlined codes covering different spheres of life and it is of great significance because it outlined the patient-physician relationship in Codes 215-223[177] with specific mention that if a physician makes an incision on a patient with the operating knife and kills the patient, the physician's hands shall be cut off. This could be regarded as one of the first laws protecting the rights of patients on record.

2.3.2.1.5 United States Declaration of Independence (1776)

The United States Declaration of Independence was approved by the United States Congress on the 4th day of July 1776. The document was primarily an explanation written by Thomas Jefferson to explain why congress had voted on the 2nd of July to declare independence from Great Britain. It doubled as a statement to announce that the thirteen American colonies[178] had been wholly seceded from the British Empire. This was the first step towards the creation of the United States of America (hereafter "USA"). The Declaration listed the grievances against the Monarchy of Great Britain and asserted some natural and legal rights inclusive of the rights of the individual and the right to a revolution. It particularly contained issues which became centrepieces for discussions on human rights, for example:

175 King LW "The code of hammurabi" https://avalon.law.yale.edu/ancient/hamframe.asp (Date of use: 13 June 2019).
176 https://www.britannica.com/topic/Code-of-Hammurabi (Date of use: 13 June 2019).
177 King https://avalon.law.yale.edu/ancient/hamframe.asp (Date of use: 13 June 2019).
178 New Hampshire, Massachusetts Bay, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Maryland, Delaware, Virginia, North Carolina, South Carolina, and Georgia.

> hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights that among these are life, liberty and the pursuit of happiness.[179]

2.3.2.1.6 The Constitution of the United States of America (1787)

The US Constitution was introduced in September 1787, ratified in 1788 and came into force in 1789.[180] This Constitution established the division of power between the three arms of government and instituted federalism in the USA. The United States Senate statement at the commencement of the Constitution, "We the people", codifies the fact that the government exists as service to the citizenry.[181]

In 1791, the Bill of Rights was added as an amendment to guarantee basic human liberties like freedom of speech and religion. The Bill of Rights also placed restrictions on the powers of the government.[182] The American Constitution through the Bill of Rights is seen as a document underscoring rights, freedoms and liberty.[183]

2.3.2.1.7 The Declaration of the Rights of Man and of the Citizen (1789)

The Declaration of the Rights of Man and of the Citizen[184] was the first step the National Constituent Assembly of the Republic of France took towards putting the nation's Constitution into force. It is a declaration of the civil rights of the citizenry birthed by the French Revolution. The preamble to the 1791 French Constitution is a repetition of the first 17 articles of the Declaration.[185] The Declaration had a

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179 Jeffers T "Declaration of Independence" https://liberalarts.utexas.edu/coretexts/_files/resources/texts/c/1776%20Declaration%20of%20Independence.pdf (Date of use: 11 June 2019).

180 https://www.senate.gov/artandhistory/history/common/generic/ConstitutionDay.htm(Date of use: 11 June 2019).

181 https://www.senate.gov/artandhistory/history/common/generic/ConstitutionDay.htm (Date of use: 11 June 2019).

182 http://www.www.loc.gov/rr//program/bib/ourdocs/billofrights.html (Date of use: 14 October 2019).

183 Liu G, Karlan PS and Schroeder CH *Keeping faith with the constitution* (Oxford University Press New York 2010) 14-16; Baldwin GB "The bill of rights" 2009 *Wisconsin Law Foundation and the State Bar of Wisconsin* 4-5, 7-8.

184 https://www.conseil-constitutionnel.fr/sites/default/files/as/root/bank_mm/anglais/cst2.pdf (Date of use: 11 June 2019).

185 https://www.britannica.com/topic/Declaration-of-the-Rights-of-Man-and-of-the-Citizen (Date of use: 11 June 2019).

major effect on the evolution of the codification of human rights in Europe and worldwide, making it a significant historical document in the evolution of rights.[186]

2.3.2.1.8 United States Bill of Rights (1791)

The Bill of Rights refers to the first ten amendments to the United States Constitution. These amendments were meant to reinforce the guarantees of human rights and place restrictions on the powers of the government.[187] The provisions of the Bill of Rights are justiciable and if the United States Congress contravenes it, their action may be voided by the United States Supreme Court in line with the Bill. The Bill was influenced by various human rights documents[188] inclusive of the Magna Carta.[189] The then Constitution of the United States[190] was federalist in nature, giving a lot of power to the centre; the Bill of Rights watered down the powers at the centre and gave the individual and the states adequate powers as well.

2.3.2.1.9 First Geneva Convention (1864)

The First Geneva Convention[191] was drafted and ratified to provide care for wounded soldiers in war situations without discrimination. It also stipulated that medical personnel and medical utility vehicles be marked with a distinctive red sign and be immune from attacks by warring factions. Although this Convention was drafted for war, it may be regarded as an early tilt towards the protection of patients. Soldiers who were wounded could be regarded as patients at this point. These provisions originated from a series of international diplomatic meetings, the first of which was the "Amelioration of the Condition of the Wounded in Armies in the Field", which was enacted in 1864.[192] The American civil war had been raging since 1861, claiming hundreds of thousands of lives. War was also raging

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186 Kopstein J and Lichbach M (eds) *Comparative politics: Interests, identities, and institutions in a changing global order* 3rd ed (Cambridge University Press United Kingdom 2008) 72.

187 https://www .britannica.com/topic/Bill-of-Rights-United-States- Constitution (Date of use: 12 June 2019).

188 Other documents are the Virginia Declaration of Rights, the English Magna Carta, the Petition of Right, the English Bill of Rights, and the Massachusetts Body of Liberties.

189 https://billofrightsinstitute.org/founding-documents/bill-of-rights/ (Date of use: 12 June 2019).

190 Constitution of the United States (1787).

191 https://www.loc.gov/law/help/us-treaties/bevans/m-ust000001-0007.pdf (Date of use: 12 June 2019).

192 https://www.icrc.org/en/doc/resources/documents/treaty/geneva-convention-1864.htm (Date of use: 12 June 2019).

in Europe – the battle of Waterloo[193] fought on Sunday 18 June 1815 near Waterloo in Belgium at which Napoleon Bonaparte was defeated and the Crimean War which ranged from October 1853 to February 1856 between the Russian Empire, the Ottoman Empire, France, Britain, and Sardinia – necessitated some concern for the protection of the wounded (patients).[194] The first Geneva Convention was instituted out of a need to ameliorate the effect of the wars. There were three more Geneva Conventions after that, which further elaborated and advanced the agenda of laws of war. The International Committee of the Red Cross and Red Crescent is the primary organization saddled with implementing and ensuring adherence to these instruments. Its symbol later became the Red Cross, and subsequently, the Red Cross and Red Crescent were the distinctive red signs which protected medical personnel from attacks in 1864. The Committee promoted the codification of the previously listed Conventions.[195]

2.3.2.1.10 The United Nations (1945)

The name, UN was first used in 1942 but was only formally established as an international organization on 24 October 1945. It started with 51 member states forming a global diplomatic and political organization to:

a. ensure international peace and stability.
b. develop amicable relations between nations.
c. achieve participation by all nations in tasks tailored to resolve world issues from economic to social to humanitarian issues; and
d. be a platform where the efforts by different nations across the world to achieve the objectives mentioned above are harmonized.[196]

193 https://www.britannica.com/search?query=the+battle+of+waterloo (Date of use: 12 June 2019).
194 https://www.britannica.com/search?query=the+crimean+war (Date of use: 12 June 2019).
195 https://casebook.icrc.org/law/implementation-mechanisms (Date of use: 12 June 2019).
196 UN Charter chapter I article 1 https://www.un.org/en/sections/un-charter/chapter-i/index.html (Date of use: 13 June 2019).

The UN Charter was signed on 26 June 1945 by representatives of the 50-member states present; although Poland signed later, it is still considered part of the inaugural 51.[197] The UN is financed by assessed and voluntary contributions from its member states. Its offices across the world are extra-territorial. The UN's missions are non-military observations by lightly armed personnel in periods of conflict.[198] The preamble of the UN Charter states as the first of its objectives, to "save succeeding generations from the scourge of war, which twice in our lifetime has brought untold sorrow to mankind" and as the last objective, "to promote social progress and better standards of life in larger freedom."[199]

The organization has lived up to these objectives by being at the forefront of most treaties, codifying the evolving rights inclusive of human rights and economic and social rights. The UN also sets forth the procedures for the implementation of these rights. There are currently 193 member states in the UN.[200] The UN Charter is important to this research as the UN is believed to be the most equipped organisation to champion and enforce a globally accepted model of patients' rights, due to its ability to impose trade and other sanctions.

2.3.2.1.11 The Universal Declaration of Human Rights (1948)

The UDHR was drafted by the UN Commission on Human Rights and adopted with a few absentees[201] on the 10th of December 1948.[202] The 30 articles of the Declaration affirm the rights of the individual.[203] It is considered binding as a customary international law because it has existed for 70 years and is a reference document for many human rights litigations and discussions.[204] However, as with international legal instruments, the extent of domestication determines the level to which it is binding within the territories of state parties to the treaty. The extent

197 https://www.un.org/en/sections/history/history-united-nations/ (Date of use: 13 June 2019).
198 UN Charter chapter VII https://www.un.org/en/sections/un-charter/chapter-vii/index.html (Date of use: 13 June 2019).
199 UN Charter preamble https://www.un.org/en/sections/un-charter/preamble/index.html(Date of use: 13 June 2019).
200 https://www.un.org/en/member-states/ (Date of use: 13 June 2019).
201 Of the then 58 members of the UN, 48 voted in favour, none against, eight abstained, and two did not vote.
202 UN Resolution 217 1948.
203 https://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf (Date of use: 13 June 2019).
204 Steiner HJ, Alston P and Goodman R *International human rights in context: Law, politics, morals* 3rd ed (Oxford University Press New York 2008) 133-135.

of domestication notwithstanding, state parties still have an obligation to adhere to the treaty and since domestication limits the application of treaties, state parties have the duty to domesticate treaties they ratify as early as possible. Non-domestication is not acceptable as an excuse for non-adherence.[205] This research recommends that patients' rights will be better protected through international organisations like the UN through its functioning organs, for example the World Health Organization (hereafter "WHO") because of the power of sanction and international cooperation among the committee of nations.

2.3.2.1.12 Human rights covenants

The two human rights covenants discussed here are the ICCPR[206] and the ICESCR.[207] While civil and political rights are considered fundamental to human existence, inalienable and always actionable, the enforceability of economic, social and cultural rights depends on the level of commitment the government has made to endow the citizens with it.[208] The latter requires a sustainable level of economic capacity and resources; in other words, the international community may not be able to enforce it without giving grants to the impoverished nations.

This issue begs the question: what about countries with high economic capacities but corrupt systems? Will the international community force their hands to use public funds to ensure citizens enjoy these economic, social and cultural rights? While that is yet to be answered authoritatively, the two covenants have specialized committees which oversee their implementation, namely the UN Human Rights Committee and the UN Committee on Economic, Social and Cultural Rights.[209]

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205 Vienna Convention on the Law of Treaties 1969 articles 26 and 27 (UN, Treaty Series, vol. 1155, p. 331) http://legal.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf (Date of use: 13 June 2019).

206 Adopted by the UN General Assembly by Resolution 2200A (XXI) on 16 December 1966 and in force from 23 March 1976 in accordance with Article 49. https://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf (Date of use: 13 June 2019).

207 Adopted on 16 December 1966 through GA. Resolution 2200A (XXI), and came in force from 3 January 1976 in accordance with article 27 https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf (Date of use: 13 June 2019).

208 See Article 12 of the ICESCR.

209 https://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf (Date of use: 13 June 2019) and https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf (Date of use: 13 June 2019).

2.4 Human rights

Human rights - which constitute the focus of this research - are a hybrid of legal rights and natural rights. Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status.[210] They are moral principles or norms which every human ought to enjoy and are protected as natural or legal rights by national, regional and international law. Human Rights are claims which individuals and groups make on society, some of which are protected by law while others remain aspirations in the future.[211] They are universal and inalienable as emphasised in the UDHR which was adopted by the UN General Assembly in Paris after the horrors of the Second World War and the Holocaust.[212]

Further discussions have given rise to four schools of thought on human rights: the natural school which conceives of human rights as "given"; the deliberative school which conceives it as "agreed upon"; the protest school which considers human rights as "fought for"; and the discourse school of thought which opines that they are "talked about".[213] The fundamental human rights are the right to life and liberty; freedom from slavery and torture; freedom of opinion and expression; the right to work and education; the right to equality; the right against exploitation; the right to freedom of religion, cultural and educational rights; and the right to constitutional remedies. Everyone is entitled to these rights, without discrimination.[214] These rights are further classified into economic, social and cultural rights; and civil and political rights which will be discussed below.

2.4.1 Civil and political rights

These are classes of human rights which protect the individual's liberty from infringement by other persons, the government or other institutions. They proscribe repression and discrimination against an individual's freedom to

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210 http://www.un.org/en/sections/issues-depth/human-rights/ (Date of use: 6 January 2019).

211 Eze O *Human rights in Africa: selected problems* (Macmillan 1984) 5.

212 https://www.un.org/en/sections/universal-declaration/history-document/index.html (Date of use: 15 June 2019).

213 Dembour MB "What Are Human Rights? Four schools of thought" 2010 *Human Rights Quarterly* 1-20. This research does not discuss further this classification but acknowledges it.

214 http://www.un.org/en/sections/issues-depth/human-rights/ (Date of use: 6 January 2019).

participate in the civil and political system of his or her community or nation. They empower the individual to get equal and fair treatment, while the civil rights protect the personal liberty and integrity of the individual too. These rights include the right to life; liberty and privacy; protection from discrimination on grounds of race, religion, sexual orientation, political affiliation, disability, national origin, freedom of thought, religion, speech, press, assembly, and movement. The political rights provide for citizens to participate in the government of their nations, vote and assemble, be heard fairly in courts and to seek remedy when needed.[215] Some of these civil and political rights are now considered.

2.4.1.1 The right to liberty and security of the person

Every human has the right to freedom and security.[216] No one should be detained in health facilities except as provided for by the law which may be upon a court order or to protect other members of the public.[217] The Human Rights Committee (hereafter "HRC")[218] held in *HRC Fijalkowska v. Poland Communication*[219] that detention in psychiatric cases is a contravention of Article 9 of the ICCPR.[220] Although it is a risk where public interest is concerned, this position may be applied to matters of patients with contagious illnesses, as the nature of illness does not immediately withdraw freedom of movement, but legal provisions for restriction must be followed. The global pandemic COVID-19 has seen an increase in compulsory detention and restriction of movement for public health and safety reasons, backed by various national and regional laws. In a similar vein, persons with disabilities and children are required to be detained only within

215 https://www.britannica.com/topic/civil-rights (Date of use: 14 February 2019).

216 ICCPR article 9 https://treaties.un.org/doc/publication/unts/volume%20999/volume-999-i-14668-english.pdf (Date of use: 12 January 2019); Protection of children ICESCR article 10(3); CRPD article 14 https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html (Date of use: 12 January 2019).

217 ICCPR article 9 (1).

218 https://www.ohchr.org/en/hrbodies/ccpr/pages/ccprindex.aspx (Date of use: 12 January 2019).

219 http://www.worldcourts.com/hrc/eng/decisions/2005.07.26_Fijalkowska_v_Poland.html (Date of use: 12 January 2019).

220 ICCPR UN General Assembly Resolution 2200A [XXI] https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (Date of use: 12 January 2019).

the provisions of the law and must be provided with reasonable accommodation and periodic evaluations during this period.[221]

Patients have continued to suffer unjustly, as their right to liberty and security of their persons has been limited by laws in various jurisdictions. These limitations have been abused, expanded, or extended wrongly especially since patients are not always in the best position to demand their rights based on their health condition. Some of these restrictions have been justified, as in the Ebola virus disease cases in Nigeria and Liberia and other parts of Africa where infected persons were quarantined until declared cured and other such cases of infectious diseases. It is however pertinent that the justification of restriction of the right of an individual to liberty based on the foregoing should not lead to the slippery slope of indiscriminate deprivation of liberty, simply because the individual concerned is a patient or ill.

In situations of arrest by the police, the Nigerian Constitution[222] endorses the loss of the right to liberty if the person is suffering from an infectious or contagious disease; or is of an unsound mind; or addicted to drugs or alcohol; or is a vagrant, for the purpose of his/her care or treatment or the protection of the community. It is common knowledge that there is no adequate care for persons whose liberty is restricted on the basis of their health in undeveloped and developing countries. The right to personal liberty is also suspended for preventing the unlawful entry of any person into Nigeria; or for the expulsion, extradition or other lawful removal from Nigeria of any person; or the taking of proceedings relating thereto.

2.4.1.2 The right to privacy

Every individual has a right to the protection of his/her privacy, correspondence, family home, and personal information.[223] The Hippocratic Oath and various

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221 Convention on the Rights of the Child UN General Assembly Resolution 44/25, Article 25 https://www.ohchr.org/en/professionalinterest/pages/crc.aspx (Date of use: 12 January 2019); CRPD UN General Assembly Resolution article 14 http://www.un-documents.net/a61r106.html (Date of use: 12 January 2019).

222 Nigerian Constitution s 35 (e).

223 UDHR article 12 http://www.un.org/en/universal-declaration-human-rights/ (Date of use: 12 January 2019); ICCPR article 17 https://treaties.un.org/doc/publication/unts/volume%20999/volume-999-i-14668-english.pdf (Date of use: 12 January 2019); CRPD article 22 https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-

Codes of practice emphasize the need for healthcare practitioners to protect the privacy of their patients. Additionally, accessibility of members of the public to information should not infringe on a patient's right to confidentiality of his/her health records.[224] For patients' information to be disclosed, the patient must have consented in writing or other legal procedures must have been adhered to.[225] The human matter, like blood or urine, among others, from which health data are extracted must also be protected.[226]

The right to privacy also implies that a patient's records should not be available on search engines if digital or discarded as wastepaper without adequate shredding if captured on paper. The patient's records need to be kept in confidentiality during treatment and thereafter.[227] The management of patient data, privacy, and protection of confidential information is globally discussed with modifications and periodic reviews in the digital sphere.

2.4.1.3 The right to information

The human right to freedom of expression includes the right to receive or impart information in writing, orally or through other media of choice.[228] Aligned with this, the HRC decided in *HRC Zheludkov v. Ukraine Communication*[229] that a patient has the right to access his medical records except legitimate justification is given otherwise, and since this had not been done in this matter, the HRC held that the state had breached the patient's right to information which might have impacted on his treatment.

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with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html (Date of use: 12 January 2019).

224 CESCR GC 14 para. 12 https://www.refworld.org/pdfid/4538838d0.pdf (Date of use: 12 January 2019).

225 WMA Declaration on the Rights of the Patients principle 8 http://dl.med.or.jp/dl-med/wma/lisbon2005e.pdf (Date of use: 12 January 2019).

226 WMA Declaration on the Rights of the Patients principle 8 http://dl.med.or.jp/dl-med/wma/lisbon2005e.pdf (Date of use: 12 January 2019).

227 *Tshabalala-Msimang and Another v Makhanya and others* (18656/07 [2007] ZAGPHC 161.

228 ICCPR article 19(2) https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (Date of use: 12 January, 2019); UDHR article 19 http://www.un.org/en/universal-declaration-human-rights (Date of use: 12 January 2019); CRPD article 21 https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html (Date of use: 12 January 2019).

229 *Zheludkov v. Ukraine*. Communication No. 726/1996 http://hrlibrary.umn.edu/undocs/726-1996.html (Date of use 12 January 2019).

Access to standard, accurate and comprehensive medical information regarding their treatment enables patients to make informed decisions on their healthcare.[230] This right to receive information is an element of the human right to standard healthcare.[231] Persons with disabilities should receive information in accessible formats and technology suitable for their needs.[232] Although patients have a right to their medical records, health status, and treatment details, they are excluded from receiving information relating to third parties who may appear in their own records.[233] Patients need to be informed in a manner which would not impair their health and they may choose other persons to receive information on their behalf.[234] Similarly, the patient's culture, language, age and other such factors need to be considered for the information to be properly understood.[235]

As with all other rights, this right needs to be disseminated to the community and patients need to receive information in person unless they are unconscious or below the age of consent. Talking to a relative about the procedure should not be regarded as enough. The patient himself/herself should be told in full all that pertains to his/her treatment. Patients' records should be accessible to them in person if the patient is of age and where it is not against a regulation or law. Cultural mindsets that put the sponsor of the medical treatment as the primary contact for dissemination of information should be discouraged, except for cases where the patient is a minor or unconscious. General exceptions like embassy and employer access to medical information must also be protected,[236] as the

230 IAPO Declaration on Patient-Centred Healthcare principle 5 http://iapo.org.uk/sites/default/files/files/IAPO_declaration_English.pdf (Date of use: 12 January 2019).

231 CESCR GC 14 para. 12(b)(iv) https://www.refworld.org/pdfid/4538838d0.pdf (Date of use: 13 January 2019).

232 CRPD article 21 https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html (Date of use: 12 January 2019).

233 WMA Declaration on the Rights of the Patients principle 7 http://dl.med.or.jp/dl-med/wma/lisbon2005e.pdf (Date of use: 12 January 2019).

234 WMA Declaration on the Rights of the Patients principle 7 http://dl.med.or.jp/dl-med/wma/lisbon2005e.pdf (Date of use: 12 January 2019).

235 IAPO Declaration on Patient-Centred Healthcare principle 5 https://www.iapo.org.uk/sites/default/files/files/IAPO%20Declaration%20on%20Patient-Centred%20Healthcare%20Poster.pdf (Date of use: 12 January 2019).

236 McHugh J "Confidentiality of employee health records ethics and legal dilemmas for occupational health nurses" 2003 *AAOHNJ* 382.

medical information gleaned by them must not be used to make prejudiced decisions.

2.4.1.4 The right to bodily integrity

The right to bodily integrity denotes that actions will not be carried out on a patient's body without adherence to the provisions of law.[237] Principally, all medical decisions should be with the consent of the patient,[238] but it is understandable that for the purposes of healthcare there may be limitations. Patients may be below the age of consent, or incapable of giving consent in cases of mental illness. Likewise, best interest decisions may be made in emergency situations with no proxy or guardian readily available to give required consent. The need to protect the public may far outweigh the delay in getting consent from a reluctant patient or getting a court order to override said consent.[239] The right to health implies the right to not be compelled to undergo non-consensual medical treatments or trials.[240] The right of a woman to obtain contraceptive advice and treatment without marital consent accentuates the place of individual autonomy in bodily integrity.[241]

Patients are at the mercy of the health workers treating them and may be prescribed medications which are still at a trial stage. This should only be done with the informed consent of the patient. The right to bodily integrity emphasizes the need for full consent of the patient in such circumstances. In the UK, South Africa, and Nigeria, patients have the right to be told in full of their diagnosis and treatment plans.[242] Low income earners, the poor and those who receive state funded treatment need to be made aware of patients' rights, so that they can

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237 ICCPR article 10 https://treaties.un.org/doc/publication/unts/volume%20999/volume-999-i-14668-english.pdf (Date of use: 12 January 2019); Article 17 CRPD https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/convention-on-the-rights-of-persons-with-disabilities-2.html (Date of use: 12 January 2019).

238 "It is a civil wrong and may be a crime to impose medical treatment on a conscious adult of sound mind without his or her consent" See *re F (Mental patient: sterilization)* [1990] 2 A.C. 1.

239 WMA Declaration on the Rights of the Patients principles 2-6 http://dl.med.or.jp/dl-med/wma/lisbon2005e.pdf (Date of use: 12 January 2019).

240 CESCR GC 14 para 8 https://www.refworld.org/pdfid/4538838d0.pdf (Date of use: 12 January 2019).

241 *Paton v Trustees of the British Pregnancy Advisory Service* [1979] QB 276.

242 See *Oldwage v Louwrens* [2004] 1 ALL SA 532(C), *Okekearu v Tanko* (2002) FWLR (pt.131) 1888, *Smith v Tunbridge Wells Health Authority* [1994] 5 Med L.R. 334.

demand their right to information, recourse and bodily integrity when in health facilities that do not disclose their rights or protect them routinely.

2.4.1.5 The right to life

The right to life implies that everyone has a right to live and the state should take all necessary measures to ensure the effective enjoyment of this right by all persons, including patients and persons with disabilities.[243] Some patients' right to life is a major issue in the rights discourse. The debate is especially centred around patients who are already critically ill when presented before a health practitioner vis-à-vis the extent of the practitioner's liability in the event of that patient's death, suggesting that when they die, the health practitioner or circumstances should not be investigated based on the probable outcomes of medical intervention.

This research states emphatically that the quality of life of a patient is no justification for the deliberate termination of a patient's life, except with the consent of the patient and within the stipulated procedure for end of life treatment. Medical errors occasioning death and negligent actions which infringe on the right to a patient's life must be a disciplinary priority by the medical self-regulatory bodies and the courts to restore public trust in the profession and importantly, to enforce the right to life or remedy a decision to contravene this right. This does not in any way suggest that a patient has the right to be healed or cured by practitioner as there is no guarantee to cure but to reasonable care and skill by the professional.[244]

The state is required to interpret the right to life as widely as possible and adopt positive measures to increase life expectancy,[245] such that unconscious victims of suicide attempts are required to be revived and mentally ill patients with

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243 UDHR article 3 http://www.un.org/en/universal-declaration-human-rights (Date of use: 12 January 2019); ICCPR article 6 https://treaties.un.org/doc/publication/unts/volume%20999/ volume-999-i-14668-english.pdf (Date of use: 12 January 2019); CRPD article 10, See also Constitution of the Republic South Africa, 1996 s 11-12, CFRN s 33(1).

244 See *Buls v Tsatsarolakis* 1976(2) SA 891 (T) 893; *Kovalsky v Krige* 1910 (20) CTR 822 at 823 and *Goliath v MEC Health Eastern Cape* 2015(2) SA 97 (SCA).

245 HRC General Comment 6 article 6 (Sixteenth session, 1982); Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies U.N. Doc. HRI\GEN\1\Rev.1 at 6 (1994) http://hrlibrary.umn.edu/peace/docs/hrcom6.htm (Date of use: 12 January 2019).

suicidal tendencies are required to be kept on suicide watch to prevent them from taking their own lives.[246] The right to life is premised on state responsibility for its citizens and its recognition that life is sacred.[247]

In *HRC Lantsova v. The Russian Federation,*[248] a pre-trial detainee fell fatally ill but was not treated. The HRC ruled that the state had the duty to get him treated irrespective of the detainee's financial state. However, in South Africa Chaskalson P in *Soobramoney v Minister of Health (KwaZulu-Natal)*,[249] held that the right to life in relation to the positive obligations imposed on the state under various provisions of the Bill of Rights on medical treatment, is dependent upon the resources available for such purposes. Thus, everyone in South Africa is entitled to have access to healthcare services provided by the state "within its available resources". This argument was also presented by Areen J when he posited that the question of right to healthcare raises a query as to the extent of the entitlements asserted. Equality of rights is relative and unequal.[250] This is because the notion of equal healthcare might presuppose a rocket-high government expenditure on health at the expense of national development and social needs such as infrastructural development and education.[251] If equality is advocated, then a decent minimum standard is expedient on the basis of what constitutes a tolerable life prospect in general.[252]

The right to life imposes an obligation on other persons not to take life arbitrarily. In some jurisdictions, legal authority may sanction death in criminal cases based on conviction and sentencing,[253] though some schools of thought question and some have abolished the right of the court to take a life.[254] The argument is

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246 Attempted suicide is still a crime in Nigeria, although the Suicide Act of the UK from which it was gleaned has decriminalized attempted suicide.

247 *Mohamed v President of the Republic of South Africa (Society for the Abolition of the Death Penalty in South Africa Intervening)* 2001(3) SA 893 (CC) 917.

248 *Ms. Yekaterina Pavlovna Lantsova v. The Russian Federation, Communication* No. 763/1997 U.N. Doc. CCPR/C/74/D/763/1997 (2002) http://hrlibrary.umn.edu/undocs/763-1997.html (Date of use: 12 January 2019).

249 [1998] 1 All SA 268 (CC).

250 Areen J *et al Law, science and medicine* 2nd ed (The Foundation Press Inc. New York 1996) 698.

251 Areen *Law, science and medicine* 699.

252 Areen *Law, science and medicine* 699.

253 CFRN s 33(1) (2).

254 See Article 1 Protocol No.13 to the Convention for the protection of human rights and fundamental freedoms concerning the abolition of death penalty in all circumstances (Protocol No. 13 to ECHR), also Human Rights Act UK(Amendment) Order 2004 s 2(3).

underscored by convicted persons who were later found to be innocent when their cold cases were reviewed. In South Africa, capital punishment was abolished in 1995 by the Constitutional Court in the case of *S v Makwanyane.*[255] The Court specifically stated that capital punishment is not consistent with the commitment of the state to human rights. The accused had been sentenced to death after being found guilty of four counts of murder. Upon appeal, the counsel for the accused requested the Court to consider sections 9 and 12 of the Constitution, which came into force after the conviction and sentencing. Thereupon, the constitutional issue was transferred to the Constitutional Court. The Constitutional Court ruled that capital punishment was incompatible with the Constitution RSA which proscribes "cruel, inhuman or degrading treatment or punishment". The UK abolished the death penalty as the punishment for murder by the Murder (Abolition of Death Penalty) Act 1965. It stipulated that the highest punishment for murder is life imprisonment. Furthermore, the Crime and Disorder Act 1998[256] abolished the death penalty for treason and piracy with violence, replacing it with a discretionary maximum sentence of life imprisonment. In Nigeria, the death penalty is still authorized by section 33 of the Nigerian Constitution thus, a court may sentence a convicted person to death for capital offenses.

With regards to patients and their right to life, it is noteworthy that life may be taken actively or passively. Euthanasia and assisted suicide are illegal in the UK,[257] Nigeria, and South Africa.[258] This implies that the active taking of a patient's life is proscribed by the laws of these countries. Nonetheless, when it comes to passively taking lives by professional incompetence,[259] errors of judgement,[260] refusal to treat poor patients, inability to give best care due to the

255 2 CHRLD 164, 1995 (2) SACR 1 (CC).
256 Crime and Disorder Act 1998 http://www.legislation.gov.uk/ukpga/1998/37/section/36 (Date of use: 1 March 2020).
257 Suicide Act 1961 s 2.
258 This will be better discussed in subsequent chapters.
259 *Collins v Administrator, Cape* 1995(4) SA 73(C).
260 *Allot v Paterson& Jackson* 1936 SR 221, *Micheal v Linksfield Park clinic (pty) Ltd* 2001 (3) SA 1188 (SCA).

unavailability of resources and such like, a good number of patients have deductively been denied their right to life over the years.[261]

2.4.1.6 The right to freedom from torture and cruel, inhuman and degrading treatment

The right to be free from torture and cruel, inhuman and degrading treatment has no reservations.[262] Some regions have means of assessing the level of torture to know if it is a breach of this right.[263] While "torture" has been defined as deliberate infliction of pain on a person to extract information or to punish, "inhuman treatment" refers to carrying out acts on the person of another to cause physical or mental pain and "degrading treatment" is treatment which causes anguish to and fear in another, to make him/her feel less human or humiliated.[264] In the European human rights framework, any perceived breach of this right which falls beneath the severity test will be categorized as a breach of the right to privacy and family life after an assessment of other factors, such as age, gender and so forth.[265]

Although this right mainly applies to criminal suspects or detainees, it is also important that patients be protected, as health workers must not be used to inflict pain or torture except as authorised by law. This right profits vulnerable people who may be destitute or receiving care from a caregiver.[266] Patients, particularly, in-patients, rely on the medical caregiver's beneficence, integrity, and sincerity of service delivery. The reality is that while out-patients may have the liberty to seek second opinions before consenting to treatment, an incapacitated person on

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261 See cases where medical negligence has led to death of the patient, *S v Shivute* 1991(1) SACR 656(Nm).

262 UDHR article 5 ; ICCPR article 7 ; CRPD articles 15 and 16.

263 European Court of Human Rights' (ECtHR) severity test to assess the breach of the European Convention on Human Rights (ECHR), article 3 https://www.echr.coe.int/Documents/Convention_ENG.pdf (Date of use: 17 January 2019).

264 Northern Ireland Civil Service "Human Rights' Guide" http://nicshumanrightsguide.com/human-rights-in-practice/victims-of-crimes-and-abuse/freedom-from-torture-or-cruel-inhuman-or-degrading-treatment-or-punishment (Date of use: 17 January 2019).

265 Northern Ireland Civil Service "Human Rights' Guide" http://nicshumanrightsguide.com/human-rights-in-practice/victims-of-crimes-and-abuse/freedom-from-torture-or-cruel-inhuman-or-degrading-treatment-or-punishment (Date of use: 17 January 2019).

266 Njilo N "Mamelodi hospital begins probe after patient, 76, is found tied up on the floor" https://www.timeslive.co.za/news/south-africa/2019-05-30-mamelodi-hospital-begins-probe-after-patient-76-is-found-tied-up-on-floor (Date of use: 13 June 2019).

admission may be treated in an emergency without regard for consent in critical situations, putting them at risk of being in the hands of potential "death-givers" instead of life-givers.

An example is the case of Harold Shipman who was convicted of fifteen murders while practising as a medical doctor in Manchester, depriving patients of their right to life. These murders were committed with lethal injections of a drug used in treating the final stages of cancer. Upon further inquiry, it was discovered that this trend existed throughout the twenty-five years of the convict's medical practice.[267] Altogether, he was indicted for complicity in two hundred and fifty deaths by a public enquiry.[268] The outcomes of the enquiries are evidence of strong monitoring of medical practice in the UK which in turn emphasizes the need for the protection of the rights of the patient.[269]

Patients with mental illnesses are usually subject to restriction of movement. Even then, they should not be subjected to more pain than is necessary for treatment, should not be used as objects of ridicule when they exhibit certain behaviours due to their illnesses or treatment regimen, and should not be the object of aggression by caregivers for slow response to treatment or other negative outcomes of treatments. The case of a seventy-six-year-old tied up in dehumanising conditions at the Mamelodi hospital is being probed by the South African Human Rights Commission (hereafter "SA HRC"). This came to the fore as it was recorded and published on various platforms online.[270] To this end, non-consensual medical treatment and withholding treatment when required have been termed inhuman and degrading treatment. In the same vein, poor living

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267 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228886/7014.pdf (Date of use: 12 February 2019).

268 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/_attachment data /file/ 273227/5854.pdf (Date of use: 12 February 2019).

269 See also a similar case of Nurse Beverley Alitt in *Allit, Re* [2007] EWHC 2845.

270 Njilo N "Mamelodi hospital begins probe after patient, 76, is found tied up on the floor" https://www.timeslive.co.za/news/south-africa/2019-05-30-mamelodi-hospital-begins-probe-after-patient-76-is-found-tied-up-on-floor/ (Date of use: 13 June 2019).
Njilo N "SAHRC to provide legal help to woman tied up at Mamelodi hospital" https://www.timeslive.co.za/news/south-africa/2019-05-31-sahrc-to-provide-legal-help-to-woman-tied-up-at-mamelodi-hospital/ (Date of use: 13 June 2019).

conditions in a nursing home or inadequate care given in cases of incontinence and required feeding, amount to inhuman and degrading treatment.[271]

2.4.1.7 The right to participate in public policy

Participation in public policy empowers the citizens to be involved in the decision-making process of their country, from agenda setting to decision making and policy formulation. The drafting and implementation of policies should not be left to elected or appointed public officers alone, because public policies ought to reflect the needs of the people in general and not just a select few. The wealth of ideas and input from all and sundry in a nation will boost the progress of such nation when utilized appropriately.

Public participation is often curtailed by the ideologies and leanings of the government of the day such that even if the citizens clamour for a certain right, it may not become policy if the ruling class or political party in power is averse to its implementation. The right to public participation places an obligation on the state to open channels of communication to the citizens to express their opinions on policies to be made, and to be adequately represented in the implementation of such policies. Attention must be paid to persons living with disabilities[272] and special categories of patients to ensure that laws, facilities, technology, and structural designs are put in place to grant them access to government and private agencies; this is so that they can engage public officers, private health investors, and attend policy meetings - thus living a full life unhindered by their disability or health condition.

The South African political system suggests it facilitates more public participation because its Constitution is based on good governance and the government is held accountable to the public through the mechanism of public participation.[273] In Nigeria, the public participatory process in policy making is dominated by the

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271 Northern Ireland Civil Service. Human Rights' Guide http://nicshumanrightsguide.com/human-rights-in-practice/victims-of-crimes-and-abuse/freedom-from-torture-or-cruel-inhuman-or-degrading-treatment-or-punishment (Date of use: 17 January 2019).

272 CRPD article 29.

273 Sebola MP "Communication in the South African public participation process: the effectiveness of communication tools" 2017 *AJPA* 27; Mulumba *et al* "Using health committee to promote community participation as a social determinant of the right to health: lessons from Uganda and South Africa" in Farmer P (*et al*) (eds) "Human rights and the social determinants of health" 2018 *Health and Human Rights Journal* 11–17.

elites, to the exclusion of the average citizen. This is however changing, as recently, the millennials started making inroads into lobbying for policies and statutes of current relevance to be passed.[274] There is, however, a great fear of intimidation by the ruling class, with threats of death and stringent economic measures against those who oppose the status quo. In the UK, the government is committed in principle and practice to carry the public along in the policy-making process.[275] For example, for the referendum of June 2016 on Brexit, 72.2% of the electorate turned out to vote,[276] yet, there is the complaint that much of public participation and input are not adequately reflected in the policies, making some members of the electorate averse to participation. The entirety of these suggests that if public participation is adopted in healthcare, there must be consistent patient feedback mechanisms, reviews, town hall meetings and evidence-based research on patient participation in healthcare decisions and management in their communities to sustain the little progress.

2.4.1.8 The rights to non-discrimination and equality

The rights to non-discrimination[277] and equality[278] are interrelated because non-discrimination is the basis for equality. Individuals should enjoy benefits on merit and not due to bloodline or race, gender or sexual orientation, origin or skin colour and so on. The Constitution RSA protects persons with lesbian, gay, bisexual, transgender, and intersex sexual orientations.[279] Nigeria on the other hand, has an Act which prohibits same sex marriage, thus indirectly endorsing the cultural discrimination against these sexual orientations.[280] An example of discrimination can be gleaned from a letter written by the Network of People Living with HIV/AIDS in Nigeria to the National Human Rights Commission (hereafter "NHRC"), alleging the dismissal of one of their members from service in the police force on grounds of auxiliary medical problems. The letter stated that other staff

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274 http://eie.ng/blog/2018/02/political-participation-in-nigeria-the-role-of-the-citizens/ (Date of use: 22 January 2019).

275 Dominic P "Public participation in the UK: lessons from the UK experience" (Background paper delivered for a SIGMA workshop on consultation 14 October 2008 Bucharest Romania) 9.

276 https://www.bbc.com/news/politics/eu_referendum/results (Date of use: 23 January 2019).

277 UDHR article 7 ; ICCPR article 2(1).

278 ICCPR article 26 ; ICESCR article 2(1) ; CEDAW article 12 ; CERD article 5(1)(e) ; and CRPD articles 43, 45 (1)(c) and 5.

279 Constitution RSA s 9(2).

280 Same Sex Marriage Prohibition Act Laws of the Federation of Nigeria 2014.

members of the police force who were dismissed, were reabsorbed after a medical screening at the police clinic but the dismissed patient with “auxiliary medical problems” pseudo-named, Aisha, was not reinstated. Letters and complaints by the commission were not responded to by the Inspector General of Police, Minister of Police Affairs and Chairman of the Police Service Commission.[281] Yet, the international framework for human rights requires that patients are treated without discrimination.

Refusal to treat a patient because of his/her sexual orientation should be enough to indict that medical worker for torture, inhuman treatment, and manslaughter or murder where it leads to death. If an act is proscribed, it is not the place of individual members of the society to punish. The court system or the appropriate authority may convict and punish while the medical worker carries out his/her obligations in health services without discrimination. This is a major discourse in the Nigerian healthcare circles today, as health workers are caught between the Hippocratic Oath and a discriminatory law. The UK is perceived to be one of the most liberal with regards to sexual orientation among the three countries compared in this thesis. The Equality Act of 2010 (UK) extended discrimination protection to all areas of human life in the UK.

Additionally, age is a critical factor of discrimination in medical care. Sadly, persons regarded as aged may be denied care under the guise that they will pass away soon whether they are treated or not.[282] This should not be the case. Pain and discomfort are often a side effect of ill health and patients should not be left in pain and discomfort merely because treating them may not necessarily increase their lifespan. Similarly, gender may be an issue in places where one gender is considered more economically beneficial than the other. Bloodline may also be a factor where elite will be given priority over unknown persons. All these should not be factors determining which patients are deserving of treatment and how they should be treated. The medical rule of triage[283] which requires health

281 NHRC The state of human rights in Nigeria 83-85.

282 Wyman MF, Shiovitz-Ezra S and Bengel J “Ageism in the healthcare system: providers, patients and systems” in Ayalon L and Tesch-Romer C (eds) *Contemporary Perspectives on Ageism* (Springer Open Berlin 2018) 193-212.

283 Iserson KV and Moskop JC “Triage in medicine, part I: concept, history and types” 2007 *Annals of Emergency Medicine* 275–81.

practitioners to attend to the worst cases first in cases of multiple emergencies except where resources are scarce so that those with prospects of quick response are attended to first is instructive to curb discrimination. The classification for treatment should be done ethically irrespective of age, status or affiliations of the patients.

2.4.2 Economic, social and cultural rights

These are a class of human rights that impact on the economic, social and cultural wellbeing of members of the society. They include the right to education, health, an adequate standard of living, self-determination, just and favourable work conditions, family life and social security, with all their incidental elements.[284] They are based on the principles of equal rights and social welfare. These rights protect the wellbeing and welfare of individuals and are protected by international, regional and national institutions. They were grouped as economic, social and cultural rights by the General Assembly of the UN resolution[285] in 1966 but came into force as a multilateral treaty called ICESCR in 1976. It is monitored by the UN Committee on Economic, Social and Cultural Rights. Some of these social, economic and cultural rights are often referred to as socio-economic rights. These rights are expounded below.

2.4.2.1 Right to education

The right to education is regarded as a fundamental human right within the international and regional human rights framework.[286] State parties are expected to provide elementary education to their citizens free of charge. States enforce this right by making it compulsory for all children within a stated age bracket to be in school during academic sessions. It is crucial for nations to pay close attention to the education of the children because the administration of all institutions and the political administration are all run by adults who were once children. What determines whether the nation progresses or retrogresses is the human factor in all machineries of the public or private sectors.

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284 United Nations General Assembly Resolution 2200A [XXI] December 16, 1966.

285 UN Resolution 2200A (XXI).

286 UDHR article 26; ICESCR article 13; African Charter on Human and Peoples Right article 25; CEDAW articles 13 and 14; and Convention on the Rights of the Child or CRC? article 28,29.

The ECOWAS court has reiterated that access to free and compulsory education is a right. The court's reiteration is premised on the fact that states have the obligation to promote the universality and indivisibility of all human rights. Evidence-based research shows that if the educational sector is not prioritized and standardized, all members of the society will suffer for it.[287]

The right to education has been tested by the courts with a declaration that this right exists and must be protected.[288] It is, therefore, inferable that the right to education is not a mere decoration to the statute but an actualisable right. Also, in relation to patients' rights and education, persons who are ill should be able to continue with their education if the illness is not contagious and they are not in a vegetative state. Students who miss continuous assessments or exams because of illness should not be penalised; their right to education must not be predicated on their wellness. Educational institutions must make policies that are patient friendly so as not to exclude students who are patients from accessing education.

2.4.2.2 Right to adequate standard of living

This provides for the right to adequate food, shelter and clothing. Individuals should have access to these basic elements of living.[289] The realization of this right is anchored on the enjoyment of four socio-cultural and economic rights, namely property, education, social security and work. Affiliated to this right, is the right to the continuous improvement of living conditions.[290] Some countries promise or offer their citizens a basic income to enable them to enjoy these rights whether they are gainfully employed or not, an example is the South African social security grant.[291]

The UDHR also includes the right to medical care and health as an element of the right to an adequate standard of living. It has been posited that the value of human dignity is directly linked to the material resources required for humans to

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287 Chimombo JPF "Issues in basic education in developing countries: an exploration of policy options for improved delivery" 2005 *JICE* 129 – 152.

288 *Registered Trustees of the Socio-economic rights & accountability project (SERAP) v the federal republic of Nigeria & Universal basic education commission* ECW/CCJ/JUD/07/10.

289 UDHR article 25 http://www.un.org/en/universal-declaration-human-rights/ (Date of use: 16 January 2019).

290 ICESCR article 11 https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (Date of use 16 January 2019).

291 http://www.sassa.gov.za/index.php/social-grants (Date of use: 12 February 2019). These grants are politicized and have little or no impact on the economic standing of most citizens.

exercise their full potential and live well. Therefore, the state ought to exert resources to ensure that conditions which cause the marginalization of some of their citizens are redressed.[292] In relation to patients, the actualization of this right may require modifications to social policies in housing, social welfare schemes and other alleviation methods, so as to ensure that patients are the first line of charge, when governments consider food, shelter and clothing for its citizens.

2.4.2.3 Right to self-determination

This protects the right of a people to seek their own political identity and work out their economic, social and cultural development. A country is sovereign in all respects and may independently decide on its constitutional status or other political and legal systems. The outcome of exercising this right grant sovereignty as a political, geographical, and social entity. The right to manage traditionally owned land and live thereon is also guaranteed under this right. Two elements of this right are cultural autonomy and independence. While the former may be granted by states to their citizens, the latter may need to be endorsed by the international community to be valid.[293] For patients, this might not be directly linked. However, persons who seek self-determination must not be discriminated against or denied health services based on their political ideology. In the same vein, the right to health services must not be withheld as a means of punishing anti-government campaigners or secessionists.

2.4.2.4 Right to just and favourable work conditions

The right to work to earn a living is critical for the attainment of all the other rights because the institutions set up to enforce these rights and the various mechanisms of enforcement need funding to deliver on their functions. Revenue utilized by states comes from merchandising mineral resources and/or taxes generated from the various economic activities of citizens.

The right to favourable and just work conditions implies that no matter the living requirements of an individual, an employer of labour needs to provide work conditions that are just and favourable. Consequently, in the case of patients who

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292 Liebenberg S "The value of human dignity in interpreting socio-economic rights" 2005 *SAJHR* 2-3.

293 https://www.unpo.org/article/4957 (Date of use: 12 February 2019).

may be employees, there is the primary requirement that workplaces should not cause a setback to employees' health.[294] Subsequent to this is that employees should have the right to paid days off work to attend to their health and employment contracts must respect health circumstances, emergency situations and pandemics.

2.4.2.5 Right to family life

This denotes the right of individuals to have family relationships and for these relationships to be respected.[295] Family here includes married couples, cohabiting couples, parents and children, siblings and near relatives like grandparents and grandchildren. The European Court of Human Rights has opined in *Vallianatos and Others v. Greece*[296] that when the definition of family is in question, recourse must be made to the societal changes with regards to which relationships constitute a family. Hence, the definition of family has become subjective.

Patients should, where feasible, be given the right to interact with their relatives no matter their conditions, especially in making medical decisions. Advanced directives including those emanating from family members must also be respected by the healthcare facility. For instance, a patient's relatives may require the setup of accommodation facilities within medical facilities, in order to provide the necessary support, make best interest decisions and be within reach. Also, the hospital may need to waive visiting hours rules for the close relatives of

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294 General comment No. 23 (2016) by the Committee on Economic, Social and Cultural Rights of the UN, on the right to just and favourable conditions of work, pursuant to the International Covenant on Economic, Social and Cultural Rights https://dcostore.ohcr.org/Selfservices/FilesHandler.ashx?enc=4slQ6QSmIBEDzFEovLCuW1aOSzab0oXTdlmnsJZZVQfoUYY19kME5pOqRbao%2BukB1Kzn1MMnQL24FFvtlldk%2F%2FF0GthE%2BTiGSATb%2BUa3WMs0%2F%2BfVfQFg02%2BY%2FTVuqU (Date of Use: 25 October 2019).

295 UDHR article 16 http://www.un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf (Date of use: 14 January 2019); ICCPR article 23 https://treaties.un.org/doc/publication/unts/volume%20999/ volume-999-i-14668-english.pdf (Date of use: 14 January 2019); and ECHR article 8 https://www.echr.coe.int/Documents/Convention_ENG.pdf (Date of use: 14 January 2019).

296 *Vallianatos and Others v Greece* (29381/09 & 32684/09) [2013] ECHR (7 November 2013) http://www.diritto24.ilsole24ore.com/content/dam/law24/Gad/Cedu%20sentenza%207%20novembre.pdf (Date of use: 14 January 2019).

patients, especially where this may aid recovery. Patients' relatives should be incorporated into patient care.

2.4.2.6 Right to social security

The right to social security grants persons who are unable to earn an income through active work, welfare support to provide for their basic needs. These are persons who may be disabled, pregnant, ill, injured at work, unemployed, or old. This category of people ought to be provided for from the public purse, so that they do not constitute a public nuisance. In *Fleming V. Nestor*[297] the Supreme Court of the US held that social security is not an earned right even for those who paid social security taxes during active employment.

In South Africa, the social security grant is administered alongside the insurance schemes for unemployment and child benefits. The UK has various social security schemes which serve different categories of indigent persons within the system. The UK's Social Security Schemes are set up in a way that beneficiaries cannot receive benefits from more than one system.[298] The query that social security issues prop up in patients' rights, is whether persons who are not actively seeking for a job should be eligible for social support. This cannot be answered, as social security or benefits are to be given on a case by case basis. A person should, however, not be denied state support because (s)he is a patient or because (s)he is unable to secure employment based on his/her sickness.

In Nigeria, there is no standard social security scheme.[299] The provision of social security is usually politically motivated and executed through different platforms, like the state-driven poverty alleviation programs, which provide vocational training for the unschooled, minimum wage paying jobs for the educated at different levels, or small-scale loans for traders and persons in extreme poverty.

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297 (1960) 363 U.S. 603.

298 Henderson C and Knapp M "Social services in the UK: an annotated bibliography" in Anheier HK and Kumar S (eds) *Social services in Europe: an annotated bibliography* (Institut fur Sozialarbeit und Sozialpadagogik e Frankfurt 2003) 382-413.

299 The COVID-19 pandemic has brought to fore the government's National Social Investment Program which is deemed as a social security mechanism to reduce poverty. This scheme claims to have identified 1.7 million poorest households but there are complaints and queries about the yardsticks used in determining these households. It is unlikely and uncertain whether patients or persons who are unable to work based on their health conditions are considered.

The Employee Compensation Act[300] also provides for compensation for employees who have accidents and get harmed on the job. This serves as cushioning for persons who might be without an income and without social support. With regards to health in Nigeria, the National Health Insurance Scheme (hereafter "NHIS") provides discounted medical services for registered persons.[301] This is also one of the few reliefs for a patient population that can barely afford healthcare.

2.4.2.7 The right to health

The right to health provides that all persons have a right to the highest attainable standard of physical and mental health. Physical and mental health is all encompassing and can be overstretched; it must however be within the limits and confines of reality. This means that citizens, including patients, should have access to clean water, affordable housing, good food, proper working conditions, medical services and a clean environment.[302] Patients' rights rest strongly on the right to health, as the right to health is the cornerstone of patients' rights.

The right to health is considered a second-generation right that is unenforceable in many nations' legal systems. The international framework for human rights, from the UDHR to various treaties which are advisory sources of law for non-ratifying countries, makes provision for the right to health. Health is all encompassing, covering wellness checks and maintenance of a sanitary environment devoid of pollution, while medical care, which is discussed later in this work, is for those who require treatment for one ailment or the other. The enjoyment of all human rights will aid the overall wellbeing inclusive of the good health of people. Actualizing the right to health is an advantage for the attainment of the desired patients' right dream.

300 Employee's Compensation Act, Laws of the Federation of Nigeria 2010 s 77.

301 National Health Insurance Scheme Act Cap 42, Laws of the Federation of Nigeria 2004 s 18.

302 Rammutla CW *The rights-based approach to development: access to healthcare services at Ratshaatsa community health centre in Blouberg municipality of Limpopo* (M Dev (Management and Law) thesis University of Limpopo 2013) 6,62-64.

It is important to note that the three jurisdictions pivotal to this research all have various provisions on human rights as stated above. A few of these are summarized below.

2.4.3 Human rights in South Africa

The Constitution RSA provides for the protection of human rights in the country.[303] Under the transitional Constitution of 1993, the rights enumerated were purely civil and political rights. The current Constitution in force retained those rights and added a few economic, social and cultural rights to it. The under-listed rights are provided for in chapter 2 of the Constitution RSA, namely:

1. The right to equality;[304]
2. The right to human dignity;[305]
3. The right to life;[306]
4. The right to freedom and security of the person;[307]
5. The right not to be enslaved;[308]
6. The right to personal privacy;[309]
7. The right to freedom of religion, belief and opinion;[310]
8. The right to freedom of expression;[311]
9. The right to freedom of assembly, demonstration, picket and petition;[312]
10. The right to freedom of association;[313]
11. The right to political rights;[314]
12. The right to citizenship;[315]
13. The right to freedom of movement and residence;[316]

303 The Constitution of the Republic of South Africa, 1996, Chapter 2.
304 Constitution RSA s 9.
305 Constitution RSA s 10.
306 Constitution RSA s 11.
307 Constitution RSA s 12.
308 Constitution RSA s 13.
309 Constitution RSA s 14.
310 Constitution RSA s 15.
311 Constitution RSA s 16.
312 Constitution RSA s 17.
313 Constitution RSA s 18.
314 Constitution RSA s 19.
315 Constitution RSA s 20.
316 Constitution RSA s 21.

14. The right to freedom of trade, occupation and profession;[317]
15. The right to fair labour relations;[318]
16. The right to a clean environment;[319]
17. The right to own property;[320]
18. The right to housing;[321]
19. The right to healthcare, food, water and social security;[322]
20. Children's rights;[323]
21. The right to education;[324]
22. The right to language and culture;[325]
23. The right to cultural, religious and linguistic communities;[326]
24. The right of access to information;[327]
25. The right to just administrative action;[328]
26. The right of access to courts;[329] and
27. The rights of arrested, detained and accused persons.[330]

Sections 7 and 8 of the Constitution RSA clearly identify those persons to whom these rights accrue. Section 7(1) specifically provides that the rights apply to all persons in South Africa, while subsection (3) states that the limitations in section 36 of the same Constitution apply. Section 36 states that the foregoing rights may only be limited by a law of general application to the extent that the limitation is "reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors." These relevant factors are then listed and include (a) the nature of the right; (b) the importance of the purpose of the limitation; (c) the nature and extent of the limitation; (d) the relationship between the limitation and its purpose; and (e) less

317 Constitution RSA s 22.
318 Constitution RSA s 23.
319 Constitution RSA s 24.
320 Constitution RSA s 25.
321 Constitution RSA s 26.
322 Constitution RSA s 27.
323 Constitution RSA s 28.
324 Constitution RSA s 29.
325 Constitution RSA s 30.
326 Constitution RSA s 31.
327 Constitution RSA s 32.
328 Constitution RSA s 33.
329 Constitution RSA s 34.
330 Constitution RSA s 35.

restrictive means to achieve the purpose. Section 36(2) further provides that save for the circumstances provided for in subsection (1), no law may limit any rights as provided for in the Constitution RSA.

The classification of human rights under the Nigerian Constitution is different from the South African counterpart and is considered next.

2.4.4 Human rights in Nigeria

The fundamental rights in Nigeria are protected under Chapter IV of the 1999 Constitution while the economic, social and cultural rights are enumerated in Chapter II but not actionable.[331] The fundamental rights are as follows:

1. The right to life;[332]
2. The right to dignity of human person;[333]
3. The right to personal liberty;[334]
4. The right to fair hearing;[335]
5. The right to private and family life;[336]
6. The right to freedom of thought, conscience and religion;[337]
7. The right to freedom of expression and the press;[338]
8. The right to peaceful assembly and association;[339]
9. The right to freedom of movement;[340]
10. The right to freedom from discrimination on the grounds of ethnic group, place of origin, circumstance of birth, sex, religion or political opinion;[341] and
11. The right to compensation for property compulsorily acquired.[342]

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331 Chap II Fundamental Objectives and Directive Principles of State Policy, the Constitution of the Federal Republic of Nigeria 1999 (hereafter the Nigerian Constitution).
332 Nigerian Constitution s 33.
333 Nigerian Constitution s 34.
334 Nigerian Constitution s 35.
335 Nigerian Constitution s 36.
336 Nigerian Constitution s 37.
337 Nigerian Constitution s 38.
338 Nigerian Constitution s 39.
339 Nigerian Constitution s 40.
340 Nigerian Constitution s 41.
341 Nigerian Constitution s 42.
342 Nigerian Constitution s 44.

The economic, social and cultural rights in Chapter II include:

1. The right to education;[343]
2. The right to shelter;[344]
3. Provision of maximum welfare, freedom and happiness of every citizen on the basis of social justice and equality of status and opportunity;[345]
4. Equal distribution of wealth;[346]
5. All citizens to be gainfully employed;[347]
6. Provision of adequate medical and health services to all citizens;[348] and
7. Protection of children from child labour and against neglect.[349]

The National Commission of Human Rights notes on its webpage that even though the rights in Chapter II are not actionable, they are complementary and hence the fundamental rights may not be fully enjoyed where these other rights are not equally enforced.[350]

2.4.5 Human rights in the United Kingdom

The European Convention on Human Rights 1950 and the Human Rights Act 1998 are the Acts of parliament that make provision for the enforcement of human rights of persons in the UK. All rights provided for in these instruments are actionable. The statutes compel the government, its offices and officers, the private sector inclusive of organisations, and individuals to treat people fairly with dignity and respect. Human rights legislation in the UK has evolved from being derived from common law to the enactment of the English Bill of Rights 1689 and the establishment of the European Court of Human Rights on 21 January 1959. Claims in human rights may, however, be founded upon any of these statutes

343 Nigerian Constitution s 18.
344 Nigerian Constitution s 16(2)(d).
345 Nigerian Constitution s 16(1)(b).
346 Nigerian Constitution s 16(2)(c).
347 Nigerian Constitution s 17(3)(a).
348 Nigerian Constitution s 17(3)(d).
349 Nigerian Constitution s 17(3)(f).
350 https://www.nigeriarights.gov.ng/YourRights.php (Date of use: 13 June 2019).

particularly because case law in human rights are replete with the older statutes.[351] The UK human rights include:

1. The right to life;[352]
2. The right to freedom from torture and inhuman or degrading treatment;[353]
3. The right to freedom from slavery and forced labour;[354]
4. The right to liberty and security;[355]
5. The right to a fair trial;[356]
6. No punishment without law;[357]
7. Respect for your private and family life, home and correspondence;[358]
8. The right to freedom of thought, belief and religion;[359]
9. The right to freedom of expression;[360]
10. The right to freedom of assembly and association;[361]
11. The right to marry and start a family;[362]
12. Protection from discrimination in respect of these rights and freedoms;[363]
13. The right to peaceful enjoyment of one's property;[364]
14. The right to education;[365]
15. The right to participate in free elections; and [366]
16. Abolition of the death penalty.[367]

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351 https://webarchive.nationalarchives.gov.uk/+/http:/www.dca.gov.uk/peoples-rights/human-rights/pdf/full_review.pdf (Date of use:19 June 2019).
352 The Human Rights Act 1998 s 2.
353 The Human Rights Act 1998 s 3.
354 The Human Rights Act 1998 s 4.
355 The Human Rights Act 1998 s 5.
356 The Human Rights Act 1998 s 6.
357 The Human Rights Act 1998 s 7.
358 The Human Rights Act 1998 s 8.
359 The Human Rights Act 1998 s 9.
360 The Human Rights Act 1998 s 10.
361 The Human Rights Act 1998 s 11.
362 The Human Rights Act 1998 s 12.
363 The Human Rights Act 1998 s 14.
364 The European Convention on Human Rights 1950 protocol 1 s 1.
365 The European Convention on Human Rights 1950 protocol 1 s 2.
366 The European Convention on Human Rights 1950 protocol 1 s 3.
367 The European Convention on Human Rights 1950 protocol 13 s 1.

2.5 Further classification of rights

Over the years, rights have been classified into civil and political or economic, social and cultural rights. Human rights may also be classified according to the period in which they emerged.[368] Generally, there are three generations of rights: the first-generation rights, the second-generation rights and the third-generation rights. The first-generation rights are principally to secure the liberty of the individual from the arbitrary action of the state;[369] they include the right to life, the right to freedom from torture, degrading and inhuman treatment, the right to liberty and security of persons and the right to fair hearings. The second-generation rights include economic, social and cultural rights; these rights are based on the submission that the first generation of rights cannot be enjoyed without a certain level of social and economic living standard; and are contained in Articles 22-27 of the UDHR including the right to work or gainful employment, the right to education and the right to adequate food, clothing and shelter. The third generation of rights include the right to development, the right to a clean environment and other social rights. There is controversy as to the justiciability and applicability of these rights.[370]

Rights are also divided into institutional and non-institutional rights by some scholars. While the former's existence is dependent on institutions, the latter include conventional rights which may emanate from moral cultures or general human rights; these are in relation to personal liberties and are rights every human should enjoy. Other categories of rights are active and passive rights. Active rights are the right to do something, while passive rights are the right not to do something. Passive rights can be further classified into positive and negative rights.[371]

It is important to note that there is no general acceptance of these classifications of rights. However, it is generally agreed that all human rights are universal, indivisible, interdependent and interrelated. The international community is

368 Oliyide O and Awolowo O *Rights* (Throne of Grace Lagos 2006) 3.
369 Oliyide and Awolowo *Rights* 4.
370 Egbomuche-Okeke *Human Rights Education* 5.
371 See Feinberg J *Rights, justice, and the bounds of liberty: essays in social philosophy* (Princeton University Press New Jersey 1980) 143-158.

saddled with the responsibility of ensuring that human rights are treated in a fair and equal manner, on the same footing and with the same emphasis.[372]

Having discussed generally human rights, there is a need to examine specific patients' rights contained in the human rights provisions.

2.6 Patients' rights

Patients' rights as spelt out several times in this chapter, accrue chiefly to persons who are receiving medical treatment in medical facilities. They are positive rights which are not only vested on patients, but also impose obligations on medical practitioners and healthcare givers. Although philosophers base their claims for equitable access to health on ethics, legal scholars and laymen call it "rights." Rights to healthcare, however, suggest ideas of grounds, limitations or correlative duties.

The question of right to healthcare raises query as to the extent of the entitlements asserted. The right to healthcare is not contained in several constitutions and only recently became a subject of debate. The omission of the right to health from different constitutions, has, in the past, given the argument for a right to health a weak legislative basis, as it is more of an inference rather than a constitutional right in many jurisdictions across the world.[373] A right is more than just an interest of an individual in a state of affairs. Rather, a claim of rights invokes an entitlement which must be given and can be demanded for. Although the term, "rights" is not an obvious restatement of equality, "quality of rights" is relative and unequal.[374]

To this end, the right to the highest attainable standard of health and the right to medical care are considered below.

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372 https://www.ochr.org/documents/professionalinterest/vienna.pdf (Date of use: 3 May 2019).

373 Areen *Law, science and medicine* 697.

374 Areen *Law, science and medicine* 698.

2.6.1 The right to the highest attainable standard of health

This right[375] is an affiliate of the right to health and has been said to be made up of the fulfilment of the other political and civil and socio-economic rights to education, work, adequate standard of living, equality, food, prohibition of torture, human dignity and all the other rights which directly impact on the wellbeing of the individual.[376] When all these rights are protected, enforced and redressed when breached, people will exist in a state of wholesome wellbeing.

What exactly is referred to as the highest attainable standard of health? Is it the standard that is expected of healthcare personnel globally, not considering whether they are in Ilesa, Nigeria, Hammanskraal, South Africa, or in Stoke on Trent, UK? Is it the highest attainable standard in the patient's location or based on available resources? This study suggests that the highest attainable standard of health should be universal, advocating that all patients be treated equally across the globe, with minimal variances based on actual limited resources. The best medical treatments should not be limited to countries or hospitals beyond the reach of the common man. It has, however, been argued that having a right to health is not the same as having equality of health.[377] The right to healthcare is a positive right requiring the contribution and finance of others. Also, what is craved for should be equal access to healthcare, not equal health per se. A patient can still be disentitled if (s)he cannot afford the treatment offered in such institutions[378] thus, a right claim to health is best construed as a demand for equality of access or entitlement to health services, including preventive and environmental measures. Likewise, a generalized right to healthcare is better situated in a country's Constitution. This shows that the idea has been judicially accepted and the courts can consequently protect it without hassle. Otherwise, the state may not be compellable to provide that which scholars believe is the ideal component of the right to healthcare.

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375 ICESCR article 12; CEDAW article 14(2)(b); Convention on the Rights of the Child article 24; CRPD article 25 and article 9.

376 This right is also connected to SDG 3 which aspires to ensure health and wellbeing for all.

377 Areen *Law, science and medicine* 700.

378 Areen *Law, science and medicine* 701.

Also, despite financial and realistic limitations to healthcare facilities and access, health practitioners should not go below the acceptable standard of care or below reason where the acceptable standard of care is unreasonable.

2.6.2 The right to medical care

Everyone has the right to be treated by a physician and other health workers when ill.[379] This right is not always easily enjoyable because medical care comes at a cost to medical workers and if the cost is not borne by the patient, it may be impossible to provide or sustain the service. Thus, whereas the right to medical care is a "right", its enjoyment is dependent on cost borne either by governments, insurance companies or individuals, noting that majority of the citizens cannot afford the real cost of healthcare. The question which arises is, does this right create an obligation on the government to provide and sponsor medical care – either through the provision of free hospitals or subsidization of charges or refunding medical workers for services delivered to persons who cannot pay? In cases where patients arrive at the hospital and the hospital insists on payment before services, will the medical workers be held liable for manslaughter if the refusal to treat leads to the death of the patient? Will the answer to the question for payment before treatment be different where it is not an emergency or a case involving communicable diseases? If the patient is not admitted and (s)he returns to the community to spread the illness, who will be held responsible for the epidemic, if the rejected patient has a communicable disease?

For countries that do not have systems in place to finance healthcare and make it available to all and sundry with fees calculated according to the income level, there should be awareness that the refusal to make this right an obligation of the government affects the workforce of such nations negatively. Therefore, for a nation to be truly progressive and positioned to champion breakthroughs in medicine, technology, and other sciences, and to experience a sustainable economic boom, provision of medical care must be first on the list of the critical obligations of the government, as only the living and well can transact, innovate or learn.

379 UDHR article 25; CMW article 28.

Likewise, medical workers should not be forced to use their personal resources to treat patients by laws which make it illegal to refuse treatment to emergency patients who cannot pay. For example, in Nigeria, the NHA imposes a fine on hospitals that refuse to treat emergencies.[380] It is unrealistic for a health facility to be expected to run as a charity when it receives no grants. Day to day running of a facility and staff retention is tied to cash flow. Public funds, however generated, need to be directed to financing medical care for the public. Similarly, patients should not be denied the best treatment available because health facilities lack manpower, equipment, medications, and medical consumables to deliver top-notch medical care to them.

Besides accidents and medical emergencies, the human body experiences wear and tear as one ages; toxins in the environment also cause ill health from time to time, and stress from different factors may also cause a breakdown in health. Medical care is a necessity even in a utopian community. However, medical facilities are expensive to maintain, making this right one that is fraught with many questions on how it may be enjoyed by those who cannot afford the cost of medical care. This study, however, suggests that although the right to health cannot be open-ended, prioritizing healthcare, promoting health insurance and promoting access to primary healthcare can help nations and the world attain the highest possible standards of health.

2.7 Conclusion

Rights are the foundation of human interaction. Rights theories have existed for ages and there is a continued need to emphasize rights and rights enforcement. This chapter has attempted an examination of the evolution and characterization of rights and has discovered that most existing theories of rights align with the existence of patients' rights and the need to protect the weak, although they are centred on the protection of human rights and liberties in general. I have argued in this chapter that all human rights are applicable to patients as they are human. Additionally, their status as patients creates an obligation on caregivers to actively and passively watch out for the realization of patients' rights. Hence, while a healthy individual may be considered to have waived his/her right when it is

380 NHA Nigeria s 20(2).

breached, seeking no redress, the fulfilment of a patient's right is tied to the caregiver or guardian, depending on the severity of the patient's incapacity.

I have argued that the development of human rights has impacted the evolution of patients' rights extensively. Almost all identifiable human rights are directly or indirectly intertwined with patients' rights. These rights have been a part of some rights codes, laws, and instruments. However, there is an increased awareness and demand for distinct rights of patients, thus necessitating the creation of separate and distinct documents for the protection of the patient.

While a healthy person might easily bring an action against torture or inhuman treatment in person, patients' guardians, advocates, and legal aid counsel have a socio-legal duty to bring such action on the patients' behalf. The realization of a patient's right is not tied to the patient's awareness of said rights alone. It is also tied to the level of awareness of the caregivers, guardians and medical workers. The attention given to human rights and its violation across the globe must be given to patients' rights.

Rights have been promoted from time immemorial, but there is still insufficient assertion and knowledge of rights. There is a need for the promotion of patients' rights and human rights across the prevailing media of information dissemination in rural and urban areas. The print and electronic media, especially radio and social media platforms, will play a great role in the attainment of a rights-based society. The implementation of international, regional and national enforcement mechanisms should be strengthened and publicized. These mechanisms through their agencies should also appoint officers to monitor compliance. The complaint systems for patients must be accessible to all categories of persons for the assertion of their rights.

The issues plaguing the actualization of rights are precarious and may not be resolved easily. There is no "one size fits all" solution, and as is my argument in this research, there must be basic minimum standards to serve as global yardsticks in upholding the rights of patients, whether in a socialist or capitalist state, developed or developing nation, amongst the rich or the poor. The rights of patients are non-negotiable.

Having laid the foundation of what rights are and the need for a distinct patients' rights legislation, I will discuss patients' rights in the jurisdictions that fall within the scope of this research, starting from existing patients' rights in Nigeria.

CHAPTER 3: PATIENTS' RIGHTS IN NIGERIA: THE DEARTH OF LAW AND ENFORCEMENT

3.1 Introduction

In the previous chapter, I considered rights, with distinct focus on human and more specifically, patients' rights in the jurisdictions of Nigeria, South Africa and the UK. I introduced the interdependence between patients' rights and human rights on the one hand and the relationship of both on the other, I underscored the need to have distinct legislation to protect patients because of their vulnerable position. I also commenced an argument on the need for a global standard of healthcare, in recognition of the right of everyone to good healthcare, regardless of the geographical and financial privilege of the patient. All these are essential, as argued, for humans to enjoy their natural rights as human beings. This underlining argument – humans must be healthy enough to fully enjoy their rights as humans – is one of the foundations of this research.

Having laid a foundation for this research, there is a need to delve into a discussion considering the individual patients' rights protection available in the choice jurisdictions of this research. Doing this will further highlight the *lacunae* this research hopes to fill, thus telling on its relevance to the global patients' rights clime, with specific impact on the jurisdictions of Nigeria, South Africa, and the UK. Chapter two is therefore the foundation for the three successive chapters in this research dedicated to examining the patients' rights currently in existence in the target jurisdictions. In this chapter, patients' rights in Nigeria is the focal point. Appraising the state of patients' rights in Nigeria will be pivotal to determining the underlying issues in the protection of patients' rights in the country, and to highlighting the areas where improvement is needed in favour of the patients. The findings of this chapter will also be instructive to jurisdictions with similar legal provisions on patients' rights, thus providing solutions to countries beyond Nigeria.

In order to fully achieve the aim of this chapter, I will begin with a brief description of Nigeria as a nation; examining the legal framework for the administration of patients' rights in Nigeria, which include: the Nigerian Constitution, the NHA

Nigeria and the Code of Medical Ethics in Nigeria. Examining these frameworks will necessitate an in-depth discussion of the human rights enshrined in the Nigerian Constitution earlier considered in chapter two, but with better appraisals of the said human rights as they affect patients' rights in the country. Via an examination of case law, I consider the impact of existing legal provisions on the clamour for patients' rights in Nigeria and test their progressive relevance and aptness to meet the teeming patients' demands over the years. I examine enforcement bodies for the rights of patients, many of which this thesis describes as able to often bark but not bite such as SERVICOM, the professional disciplinary councils and other patients' rights enforcement mechanisms in Nigeria. This examination highlights the areas of strength and weakness in the administration of the prevalent patients' rights legislation in the country. I also analyse the Patients' Bill of Rights,[381] with a view to determining if the fall-shorts in the pre-existing legislation have been adequately addressed in the Bill which is the most recent document on patients' rights in the country.

3.2 Nigeria as a nation

The Federal Republic of Nigeria is a sovereign state in West Africa with about two hundred million residents.[382] It is a federation which runs a three-tier system[383] consisting of component units called states which, in turn, consist of smaller units called local government areas.[384] The health system is managed by both the federal and state governments. The Nigerian Constitution delineates government reach by separating matters handled by the federal government in the exclusive legislative list, matters concomitantly handled by federal and state governments in the concurrent list and matters reserved for the state governments in the residual list. Health is a social service in the concurrent list, making it both a federal and state concern in relation to legislation and regulation.[385] Healthcare services are solely regulated by the government but provided by both public and private healthcare workers.

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381 Nigeria's patients' bill of rights http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 20 February 2020).

382 http://worldpopulationreview.com/countries/nigeria-population/ (Date of use: 27 July 2019).

383 Federal, state and local governments.

384 Nigeria has 36 states and 774 local governments listed in the Constitution.

385 The Second Schedule to the Nigerian Constitution schedule 17(a); Pascal et al 2017 BLDE Univ J Health Sci 98.

Patients in Nigeria encounter various challenges, primarily because standard healthcare is expensive and the majority of citizens live below the poverty line.[386] There is also a disparity between private and public healthcare.[387] There is widespread deterioration of health and public infrastructure which makes patients' rights a tall order when weighed against other daily challenges faced as a result of being a Nigerian resident.[388] Paternalism thrives in the Nigerian health sector, as most patients unknowingly defer to their doctors as final decision makers in medical decision-making.[389] This is because of the illiteracy and ignorance of patients, further worsened by the power healthcare practitioners arrogate to themselves which allows them to infringe on patients' rights knowingly or unknowingly.[390]

The question, however, is: are there legal frameworks in place to protect the rights of patients in Nigeria on one hand, and regulate the conduct of the medical practitioners on the other; and are these frameworks adequate? This question is considered subsequently.

3.3 The legal framework for patients' rights in Nigeria

The major legal framework regulating the health sector in Nigeria comprises of the Nigerian Constitution, the NHA Nigeria and the Code of Medical Ethics in Nigeria. The Patients' Bill of Rights which is a soft law and was not passed into law by the National Assembly,[391] was promoted and launched by the FCCPC and the Nigeria Federal Ministry of Health at the time this thesis was written.

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386 Oduor J, Verdier- Chouchane A and Wafula M https://www.afdb.org/fileadmin/uploads/afdb/Documents/Generic-Documents/country_notes/Nigeria_country_note.pdf (Date of use: 7 December 2018). See also https://www.bbc.com/news/world-africa-17015873 (Date of use: 7 December 2018).

387 Onyewu 2016 *J Nurs Care* 10.

388 Welcome MO "The Nigerian health care system: need for integrating adequate medical intelligence and surveillance systems" 2011 *J Pharm Bioallied Sci* 471-472.

389 Pascal *et al* 2017 *BLDE Univ J Health* Sci 98.

390 Pascal *et a*l 2017 *BLDE Univ J Health* Sci 98.

391 For the purposes of law making, Nigeria has a bicameral legislature at the federal level called the National Assembly, comprising of the Senate and the House of Representatives. There is a unicameral legislature at state level called the State House of Assembly. The National Assembly must approve a Bill and then the President assents to the said Bill before it becomes law. Bills may be sponsored by members of the parliament, the executive or by a member of the public. The Bills pass through the first reading, second reading, committee stage, voting/approvals, and presidential assent.

The rights of patients, although subsumed in the concurrent legislative list, ought, like every other fundamental right, to derive its validity from the Nigerian Constitution. While the Constitution provides for the fundamental rights of all Nigerians, the sector-specific legislations provide for service providers and all who access the health sector in the country.[392] Judicial precedents are also instructive for the application and interpretation of these statutes; and are binding if pronounced by superior courts of record. These are components of the legal framework that will be discussed under this chapter, with inference on their sufficiency to adequately secure patients' rights in Nigeria.

3.3.1 The Constitution of the Federal Republic of Nigeria 1999

The Nigerian Constitution guarantees rights and freedoms for everyone. It is regarded as the *grundnorm*; the law from which every other law derives its credibility and with which consistency is required.[393] It provides for a right to life;[394] a right to health;[395] a right to dignity of the human person;[396] a right to freedom from discrimination;[397] a right to freedom of thought, conscience and religion;[398] private and family life; and personal liberty.[399] Although there are other rights, the foregoing are those particularly relevant to patients.

3.3.1.1 The right to life

The Nigerian Constitution states that:

> every person has a right to life, and no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria.[400]

It proceeds to state exceptions to this right including situations where, with permission of law and reasonable force, a person is killed while another defends

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392 Sector specific provisions include the National Health Act and other specific professional ethical guidelines.
393 Nigerian Constitution s 1(3).
394 Nigerian Constitution s 33.
395 Nigerian Constitution s 17(3)(d).
396 Nigerian Constitution s 34.
397 Nigerian Constitution s 42.
398 Nigerian Constitution s 38.
399 Nigerian Constitution s 37.
400 Nigerian Constitution s 33(1).

himself or his property from unlawful violence;[401] where death occurs when effecting an arrest or preventing an escape of a lawfully detained person;[402] or for the purpose of suppressing a riot, insurrection or mutiny.[403]

The right to life is applicable to all patients in Nigeria.[404] The courts interpreted and applied this right in a medical context in the case of *Akintade v MDPT*[405] where a doctor was suspended by the Medical and Dental Practitioners Tribunal for infamous conduct in a professional respect. The court held that the doctor caused the death of a patient as he failed to attend to the patient promptly, was incompetent in the assessment and diagnosis of the patient, in addition to administering grave treatment and operational errors. The doctor appealed his suspension from practice for six months after having been found guilty of some of the charges against him. The case is revisited in the latter part of this chapter in detail, as it is a key case about the protection of patient's rights in modern Nigeria, considering the great distance between medico-legal cases on record in the nation.

Similarly, in *R v Akerele,*[406] a physician was arraigned on a charge of manslaughter having been accused of injecting an overdose of a treatment mixture for yaws. It was administered to fifty-seven children, ten of whom died because of the mixture. The high court found the doctor guilty of manslaughter based on the prosecution's emphasis on the mixture's potency. However, the Privy Council, which was the highest court at that time, overturned the decisions of the lower courts on the basis that while the accused's action was negligent, it could not be deemed as gross negligence based on the actual result of the conduct.

3.3.1.2 The right to health

The right to health is provided for in chapter two of the Nigerian Constitution. The chapter which is non-justiciable, provides for the fundamental objectives and

401 Nigerian Constitution s 33(2)(a).
402 Nigerian Constitution s 33(2)(b).
403 Nigerian Constitution s 33(2)(c).
404 Lokulo-Sodipe 2009 *J. Law. Conflict. Resolut* 82.
405 [2005] 9 NWLR 338.
406 [1941] 7 WACA 56.

directive principles of state policy, elucidating the duty of the government to the people. Here, the Constitution directs that state policy must ensure that "there are adequate medical and health facilities for all persons".[407] However, because the government cannot be compelled to implement this position, it is at best, dated law.

Additionally, standard healthcare is expensive to provide, hence an assessment of the level of adherence to this provision must be relative to the financial and human resources available and deployed to the health sector. Where outmoded medical machinery is in use because of the incapacity or unwillingness of the government to procure up to date equipment, a patient's right to receive quality healthcare may be adversely impacted. Similarly, where health workers are lost to nations which offer them better staff benefits, the right to health of the Nigerian patient cannot be actualized because of the low doctor-patient ratio.[408] Furthermore, though the government regulates health service provision, the bane of corruption has created a loophole that allows hospitals to breach the existing laws, policies and regulations if they can offer financial inducement to convince the inspectors to ignore all lapses seen in their medical facilities.[409]

3.3.1.3 The right to dignity of human persons

The Nigerian Constitution preserves the right to dignity of a person, protecting him/her from torture, inhuman or degrading treatment.[410] The custom in Nigerian hospitals is for a relative to stay with in-patients because the facilities are understaffed, and the patients' needs may not be attended to in good time. This may mean that some patients who have no relatives to care for them will be deprived of round-the-clock care and attention during their hospitalization and that relatives who lack the necessary professional nursing skills will not care for these patients properly.

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407 Nigerian Constitution s 17(3)(d).

408 Mbanefoh, N "Brain drain in the health sector of Africa: examples from the University College Hospital (UCH), Ibadan Nigeria http://ahero.uwc.ac.za/index.php?module=cshe&action=viewtitle&id=cshe_382 (Date of use: 1 March 2020).

409 Tormusa DO, Idom AM "The impediment of corruption on the efficiency of healthcare service delivery in Nigeria" 2016 *OJHE* 1.

410 Nigerian Constitution s 34(1)(a).

In the same vein, overworked caregivers are often in the habit of speaking harshly and condescendingly, even to out-patients; verbally abusing and degrading them, which is clearly unconstitutional and inhumane.[411] Seeking redress for an infraction may be too expensive and demanding for a patient, as witnesses will be needed, in addition to the need for an expert witness to corroborate the effect this degrading and inhumane treatment may have had on a patient. Beyond these challenges, Nigerians are generally averse to litigation.[412] All these factors make the enforcement of this right difficult.

3.3.1.4 The right to freedom from discrimination

Section 42 of the Nigerian Constitution preserves the right of citizens to freedom from discrimination. The section states:

> A citizen of Nigeria of a community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person-
>
> (a) be subjected either expressly by, or in the practical application of, any law in force in Nigeria or any executive or administrative action of government, to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religion or political opinions are not made subject; or
>
> (b) be accorded either expressly by, or in the practical application of, any law in force in Nigeria or any such executive or administrative action, any privilege or advantage that is not accorded to citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religious or political opinions.[413]

In the face of this obvious constitutional provision, most buildings hosting healthcare facilities are not designed to be accessible for disabled persons.[414]

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411 Ehiemere IO et al "Helpless patients' satisfaction with quality of nursing care in federal tertiary hospitals, Enugu, South East, Nigeria 2011 IJNW 12 on the need for attitudinal change among nurses in a bid to achieve patient satisfaction.

412 Frynas JG "Problems of access to courts in Nigeria: results of a survey of legal practitioners" 2001 *SLS* 8-9 on problems of accessing courts in Nigeria. Although this research focused on oil-research litigation, it shows a fair picture of discouragement from seeking legal redress.

413 Nigerian Constitution s 42(1) (a-c).

414 Eleweke CJ and Ebenso J "Barriers to accessing services by people with disabilities in Nigeria: insights from a qualitative study" 2016 *Journal of Educational and Social Research* 117-118. See also Hamzat TK and Dada O "Wheelchair accessibility of public buildings in Ibadan, Nigeria" https://www.researchgate.net/publication/228468569_Wheelchair_accessibility_of_public_buildings_in_Ibadan_Nigeria (Date of use: 7 December 2018).

Also, with about five hundred and twenty-one languages[415] being spoken in Nigeria, there are also tribal sentiments and language barriers in many health establishments. Additionally, the Same Sex Marriage (Prohibition) Act[416] has codified the cultural discrimination against homosexuals, endorsing the difficulty which may be encountered when they attempt to access Nigerian health facilities.[417] These factors suggest a clear infringement on rights of patients.

3.3.1.5 The right to freedom of thought, conscience and religion

The Nigerian Constitution provides that every person shall be entitled to freedom of his/her thoughts, conscience and religion.[418] This is a crucial right, as many medical decisions by patients are guided by their religious perspectives and thought patterns. Worthy of mention is the Christian sect called the Jehovah's Witnesses, with members unflinchingly adhering to their doctrine against receiving blood transfusions,[419] sometimes with a tragic outcome. The medical practitioners are not liable for fatal outcomes of a patient's refusal to receive lifesaving treatment on the ground of religion. This is because Section 38 of the Constitution promotes the right to change, manifest and propagate one's religion in practice and observance.

The case of *Okonkwo v MDPT*[420] is relevant in this regard. The case is elucidated in a later section of this chapter. It is noteworthy that although the Medical and Dental Practitioners Tribunal in this case held the medical doctor liable for the avoidable death of a patient who had refused a blood transfusion, on religious grounds that the Holy Bible[421] forbids it, the decision of the MDPT was overruled by the Supreme Court on the ground that although the doctor was to uphold the Hippocratic Oath to save lives, he could not do that against the will and rights of

415 https://www.onlinenigeria.com/languages/languages.asp. (Date of use: 7 December 2018).
416 Same Sex Marriage (Prohibition) Act 2013.
417 Isaack W "'Tell me where I can be safe' The impact of Nigeria's same sex marriage prohibition Act" https://www.hrw.org/report/2016/10/20/tell-me-where-i-can-be-safe/impact-nigerias-same-sex-marriage-prohibition-act (Date of use: 1 March 2020).
418 Nigerian Constitution s 38(1).
419 Kiran Chand N et al "Management of patients who refuse blood transfusion" 2014 Indian J Anaesth 658, see also https://www.jw.org/en/jehovahs-witnesses/faq/jehovahs-witnesses-why-no-blood-transfusions/ (Date of use: 1 March 2020).
420 [2001] 7 NWLR (pt. 711) 206.
421 The Holy Bible King James Version Leviticus 17: 10-11 and Acts 5: 29.

the patient. A further discuss in this chapter explains how a patient's right to determine what shall be done to his own body as in this case may be interpreted to include the patients' right to die.

3.3.1.6 The right to privacy and family life

The Nigerian Constitution protects the privacy of citizens. This right excludes telephone conversations, telegraphic messages and other correspondence[422] from public interference. In the same manner, this sanctions the right of a patient to the confidentiality of his/her communications with medical service providers. This right may be breached where there is a conflict between private life and public interest. Communication intercepted because of public health and safety risks are exceptions to the enjoyment of this right. Nonetheless, a patient's correspondence with the healthcare facility is protected under this section of the Constitution[423] until good cause is shown to the contrary.

3.3.1.7 The right to personal liberty and freedom of movement

The Nigerian Constitution guarantees the right of every person to their personal liberty[424] with some exceptions, one of which is that "persons suffering from an infectious or contagious disease, persons of unsound mind, persons addicted to drugs or alcohol or vagrants" may be held against their will. This breach is purported to be for their care, treatment or for the protection of the community.

Akin to the above, the right to freedom of movement for all citizens as provided for in the Nigerian Constitution has certain exceptions, for example, preventing criminal offenders from escaping, imprisonment of convicted persons, or repatriation.[425] This right is often breached by medical facilities that detain patients for their inability to pay hospital bills even though none of the exceptions to this right as provided for in the constitution, avails the medical practitioners the right to detain fee-defaulting patients.

422 Nigerian Constitution s 37.
423 *Okonkwo v MDPT* [2001] 7 NWLR (pt. 711) 206.
424 Nigerian Constitution s 35(1).
425 Nigerian Constitution s 41(1)(2).

A Nigerian newspaper, the *Punch*, reported an investigation that was done on new mothers being detained by hospital authorities because they were unable to settle their bills.[426] Noteworthy was the story of Mrs. Chinyere Nlemuwa, who was seen sweeping the floor of the Imo Specialist Hospital in Owerri, Imo State in Nigeria. She had been "recruited" by the hospital to pay her bills with the cleaning service. She birthed a baby boy on the 10th of December 2017, but her husband abandoned her. Upon her discharge and inability to pay the bills of twenty-five thousand Naira (NGN 25 000), equal to about seventy US Dollars ($70), the hospital "detained" her until her service had adequately offset the said bill. As at the time of the investigations for the compilation of the article, she was feeding on goodwill donations by patients and staff of the hospital. The story above is replicated in many Nigerian health facilities. The newspaper also referred to a report by a non-governmental organization which found that out of about four hundred and forty-six women who gave birth at the Enugu State University Teaching Hospital in 2012, ninety-eight were reportedly detained because they could not pay their hospital bills.[427] Also reported, was the case of Rockson Chinedu, who paid the outstanding sum due on his wife's caesarean section bill with a cheque, but his wife was detained for two weeks post her discharge, until the cheque was cleared by the bank. Blessing Agbo, another patient, was detained in a hospital in Lagos for four months because her unemployed husband was unable to pay the hospital bill. In a bid to flee detention, Sarah Ademola, a new mum who delivered twins, fled the Felken Maternity Centre in Lagos leaving the twins behind; she stayed away until well-meaning Nigerians paid the bills and resettled her.[428] The affected patients described their ordeal as distressing.

A decline in per capita income and worsening poverty levels, suggest that the number of people being "detained" might have increased after the report. This is, sadly, common practice in Nigeria, and reveals the frequency of the infringement of patients' rights to personal liberty and freedom of movement.

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426 https://punchng.com/from-labour-room-to-detention-5centre-tales-of-new-mums-held-by-hospitals-over-unpaid-bills/ (Date of use: 28 September 2018).

427 https://punchng.com/from-labour-room-to-detention-5centre-tales-of-new-mums-held-by-hospitals-over-unpaid-bills/ (Date of use: 28 September 2018).

428 Udeajah G "Abia governor's wife rescues indigent nursing mothers detained over hospital bills" https://guardian.ng/news/abia-govs-wife-rescues-indigent-nursing-mothers-detained-over-hospital-bills/ (Date of use: 29 September 2018).

The psychological and medical dangers to "detained" mothers and children are numerous. Nonetheless, Dr Uche Uduji, a medical practitioner renowned for detaining debtor patients stated that the failure of patients to pay for healthcare affects hospitals adversely. The consensus is that the only options are either treating patients and detaining them to ensure payment or refusing to treat patients who will not pay before treatment. The then president of the Nigeria Medical Association, Dr. Mike Ogirima, emphatically stated that the trend is illegal. He further blamed the Federal Government, as he believed the NHIS would compensate medical facilities and permit poor patients to enjoy their right to personal liberty.[429]

3.3.2 The National Health Act 2014 (Nigeria)

The NHA Nigeria is the principal legislation that primarily and directly provides for healthcare and patients' rights protection in Nigeria. The promulgation of this law was expected to bring relief, although before it was passed to law, some writers had pointed out flaws. Nonetheless, it is a glass half full despite its low level of actualisation. Some of the unique provisions of the Act and their implications are discussed below.

3.3.2.1 National Health System

The Act provides for the establishment of a National Health System to encompass public and private healthcare providers,[430] with the aim of promoting co-operation and shared responsibility among them. The National Health System is created to provide the "best possible health services within limits of available resources",[431] as well as set out the rights and obligations of healthcare workers, users, providers and establishments,[432] with the objective of promoting the constitutional right to healthcare services.

3.3.2.2 Federal Ministry of Health

429 https://guardian.ng/news/abia-govs-wife-rescues-indigent-nursing-mothers-detained-over-hospital-bills/ (Date of use: 29 September 2018).
430 Nigerian NHA part 1(1).
431 Nigerian NHA part 1(1)(c).
432 Nigerian NHA part 1(1)(c).

The Act empowers the Federal Ministry of Health to co-ordinate healthcare related activities through the Minister of Health. The Act places on the ministry, the responsibility of ensuring the development of a national health policy and of ensuring collaboration with local and state governments and international agencies. The ministry is also empowered to ensure the provision of tertiary and specialized hospital services. Additionally, of crucial importance to patients' rights, the ministry is required to "promote the availability of good quality, safe and affordable drugs, essential medical commodities, hygienic food, and water."[433] It is, however, unfortunate that the nation's healthcare is in a comatose state, highlighting the failures and incapacity of the ministry to provide adequate health services. This is better illustrated by the high rate of medical emigration from Nigeria which has not been deterred by ministers of health.[434]

3.3.2.3 Basic Healthcare Provision Fund

The Act provides for the creation of a Basic Healthcare Provision Fund (hereafter "the Fund"), which could have a significant impact on patients' rights to healthcare in Nigeria. The Fund is expected to be sourced from not less than one percent of the nations consolidated revenue fund.[435] Yet, the rights of patients could be better protected if this section was guaranteed, as fifty percent of the funds that accrue will be for the "provision of a basic minimum package of health services to citizens, in eligible primary and secondary healthcare facilities through the NHIS". This could guarantee a larger number of patients their right to healthcare, as twenty percent of the fund is earmarked for drugs and vaccines, ten percent for development of human resources and a crucial five percent will be for emergency medical treatment, a right which is denied to many Nigerians. The Fund must be administered by a committee appointed by the National Council on Health, headed by the Minister of Health.

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433 Nigerian NHA s 2(1)(l).

434 Akinkuotu E "Doctors free to leave Nigeria, we have enough-Ngige" https://punchng.com/doctors-free-to-leave-nigeria-we-have-enough-ngige/ (Date of use: 1 April 2020). See also Toromade S "Minister of health says some doctors should become farmers instead of specialists" https://www.pulse.ng/news/local/adewole-minister-of-health-says-some-doctors-should-become-farmers-instead-of/jqy8q1h (Date of use: 2 April 2020).

435 The fund is created by s 120 of the Nigerian Constitution.

It is unfortunate that although this Act has the force of law, it is yet to be functional, as most of the provisions are mere theory and not yet a reality. It is expected that there will be a gradual actualization of the Act; meanwhile, the rights of patients are being trodden upon daily. This will continue until a framework has been implemented that protects them. The absence of a universal functional national healthcare law that is enforceable and enforced puts the patient in continued danger and their rights in jeopardy.

3.3.2.4 Emergency treatment

The NHA Nigeria, in directing the health worker and thereby protecting a vital patient right, states that:

> A healthcare worker, provider or establishment shall not refuse a person emergency medical treatment for any reason.[436]

There are multiple reports of patients being refused healthcare in Nigerian healthcare facilities either because they are believed to be unable to pay for the health services,[437] they are victims of gunshots, or they are accident victims who cannot be recorded. The Act prescribes a punishment of a hundred thousand Naira (NGN 100,000.00)[438] or a prison term of a period not exceeding six months for a healthcare worker, provider or establishment that refuses to provide emergency medical treatment. It is worth mentioning that this section is one of the few sections in the Act that prescribes a clear punishment for contravention. However, no healthcare worker or facility has been brought before a court under the provisions of the Act. It would be of great interest to see how courts will interpret this section, considering healthcare financing and cost. This realization of the right to emergency treatment would require the adherence and adoption of the five percent from the Healthcare Provision Fund which is to be utilized for emergency medical treatment across the country. The novel COVID-19 pandemic carted in a resurgence of the practice of trampling on patients' rights

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436 Nigerian NHA s 20.

437 Anaba I, Abdulah A and Obinna C "Cash before treatment in Nigerian hospitals: doctors, lawyers, other Nigerians react" https://www.vanguardngr.com/2009/07/cash-before-treatment-in-nigerian-hospitals-doctors-lawyers-nigerians-reacts/ (Date of use: 4 October 2018).

438 Equivalent of about two hundred and seventy-four US dollars ($274) or 4000 rand.

to emergency treatment, as a large number of healthcare facilities have refused patients out of the fear of the pandemic.[439]

3.3.2.5 Minister and Commissioner for Health

The Minister of Health is saddled with numerous responsibilities in Nigeria. The execution or otherwise of duties outlined for the office determine the indices of healthcare development in the nation. The Act states that the Minister at the federal level and the Commissioner of health at state level must determine the conditions of service of healthcare practitioners and workers and protect them from injury, damage, and disease transmission. The Minister or Commissioner for health through the ministry of health must issue a Certificate of Standards to healthcare providers and establishments who qualify to treat patients and meet the basic minimum standards, set by the council.[440]

This suggests that all healthcare providers must be certified to provide health services. By the provisions of the Act, a grace period is provided, to the effect that if any provider or establishment is not certified within twenty-four months from the date of the signing of the Act, a fine of not less than five hundred thousand Naira (NGN 500,000) or a prison term not exceeding two years, or both, will be ordered.[441] This rule affects both existing and prospective healthcare establishments, individuals, and facilities. The certificates are also required for expansion of healthcare establishments. There is no proof that this provision is being complied with, but it is believed that adherence to standards in the issuance of a Certificate of Standards will improve patients' rights in Nigeria. Through the Act, the Minister and Commissioners have been made gatekeepers, and indirectly, advocates for patients' rights by providing the additional hurdle of a certificate for anyone who desires to treat patients.

3.3.2.6 Duties of healthcare personnel

Although the aim of the NHA Nigeria is to direct and thereby protect the healthcare personnel, the duties prescribed for the healthcare personnel are

439 Makinde F *et al* "FG, private hospitals disagree over COVID-19 treatment" https://healthwise.punchng.com/fg-private-hospitals-disagree-over-covid-19-treatment/ (Date of use : 10 April 2020).
440 Nigerian NHA s 13(1)-(3).
441 Nigerian NHA s 14.

conversely the rights of patients guaranteed by the Act. The Act states that the healthcare user (a term used for patients) must have "full, relevant information regarding his/her health"[442] for treatment purposes. The Act further states that where it is not in the patient's best interest, the information should not be given.[443] It appears that this provision conflicts with the Nigerian Constitution, as it limits access to information by patients based on the undefined "best interest" cloak. The Act also states that a user (patient) must be informed of the range of diagnostic and treatment options available including benefits, risks, cost and consequences of the medical treatment.[444] The Act, in protecting patients, states that the user's right to refuse medical treatment must be upheld but this must be done with a clear explanation of the risks attached to the refusal of such treatment.[445]

The Act introduces a new dimension to patients' rights by directing the healthcare professional to make information available to the user in a language (s)he understands and in consideration of his/her level of literacy.[446] The Act also expands the rights of patients to information by instructing both private and public healthcare providers to inform patients of the type of health services being run at a facility, their opening hours, visiting times and complaint procedures.[447]

Contrary to the aim of its enactment, since its coming into force in 2014, the NHA Nigeria has failed in its attempted to revamp the health system and protect the patient.

3.3.3 The Code of Medical Ethics in Nigeria

The Code of Medical Ethics (hereafter "the Code")[448] is a body of rules established to guide medical and dental practitioners in Nigeria. The Code was formerly known as the Rules of Professional Conduct before it was reviewed and renamed the Code of Medical Ethics. A violation of the Code is deemed

442 Nigerian NHA s 23(1).
443 Nigerian NHA s 23(1)(a).
444 Nigerian NHA s 23(1)(b) and (c).
445 Nigerian NHA s 23(1)(d).
446 Nigerian NHA s 23(2) It is uncertain how feasible this is in rural areas as Nigeria has over four hundred ethnic groups and over two hundred languages in these areas.
447 Nigerian NHA s 24.
448 www.mdcnigeria.org/downloads/code of conduct.pdf (Date of use: 9 July 2019).

professional misconduct and can lead to disciplinary action. The Code is important to patients' rights because it directs practitioners and outlines their duties which in turn underscores the rights of patients which is on the other end of the duties of practitioners.

The above infers that while the Code was written with the practitioner in mind, the patient may deduce his/her rights from the conduct expected of the practitioner. An alleged breach of the Code is investigated by the Medical and Dental Investigating Panel (hereafter "the Panel") and once the panel concludes that the breach is factual, the matter proceeds to the Medical and Dental Practitioners Tribunal where penalties may range from admonition, to suspension for not more than six months or worse, striking off the name of the practitioner from the register of medical practitioners.[449]

This research broadly highlights the relevant rules in the Code linked to patients' rights and discusses the practicability and feasibility of the rules, as discussed below.

3.3.3.1. Rule 8: The international code of medical ethics (Declaration of Venice 1983)

According to this rule, the physician owes the patient loyalty. Physicians have a duty to preserve the lives of patients and as emphasized in other legal documents, must refer patients to some other physician(s) where they are incapable of treating or examining the patients.[450] The rule aligns the Code with the Declaration of Venice, accentuating the importance of global standards and practice in Nigerian medical practice. The obligation to preserve life has been queried in the patients' rights discussion, where there is a conflict between abiding by the oath to preserve life and patients' rights to make individual decisions, especially where it will lead to a loss of life. The Nigerian law does not support euthanasia in any form, however, the case of *MDPT v Okonkwo*,[451] discussed above shows that the courts are prepared to allow individual freedom

449 The Code Rule 25.
450 The Code Rule 8(b).
451 (2001) 7NWLR (pt 711) 206.

even when it may lead to the loss of the patient's life. A right to referral has also been adopted in the Patients' Bill of Rights.

3.3.3.2 Rule 9: General principles of the ethics of medical and dental practices in Nigeria.

As part of the general principles of the Code, this rule highlights that promotion of the health of the patient; and respect for human dignity, community health and the common good should be the intent of the medical practitioner. The practitioner is expected to expose unethical practices by incompetent and unethical practitioners, although there are certain sections of the Code which emphasize the camaraderie and allegiance doctors are to have to the profession and the corporate body of the profession. An example is Rule 40, which states that it is misconduct for a doctor who possesses information to instigate an affected patient to start litigation where (s)he is not a relative of the patient.[452]

Practitioners are also expected not to bargain with patients for a contingent fee as condition for giving evidence, although they may get a reasonable and non-contingent fee as expert witness or for writing reports for solicitors and insurance companies.[453] Although lawyers can receive contingent fees, medical practitioners are forbidden by the Code to do same. It is uncertain what effect this might have on patients' rights protection. It might serve as precaution to practitioners who want to violate patients' rights knowing there is another practitioner waiting to nail them either for good cause or for his profit; although this might be initially chaotic with a barrage of cases expected, with time, it is expected to subside and improve patients' rights awareness.

3.3.3.3 Rule 10: Rights and responsibilities of members of the medical profession

The quandary that many health practitioners face in Nigeria, as in other developing countries, is that of inadequate resources. The Code under this rule persuades doctors to exercise ingenuity and initiative to secure best possible results for the patient.[454] This is a daunting task, as many practitioners wriggle out of their duty of care based on lack of or insufficient resources by the

452 The Code Rule 40.
453 The Code Rule 46.
454 The Code Rule 10(e).

healthcare establishment. Despite this admonition to do all that is possible for the patient, the practitioner is, however, warned not to embark on any treatment (s)he does not have knowledge, competence or resources for. This caveat may allow doctors to desert patients when additional efforts could have been undertaken. The courage to exercise ingenuity must not be doused by a counter instruction not to embark on treatment without knowledge or resources. Although patients must be treated with the utmost skill and competence, in emergency situations and conditions warranting the saving of life, any practitioner qualified should nonetheless be willing to save a patient's life without fear of breaching the Code. The rule further advises medical practitioners to protect their practice by taking professional indemnity insurance.[455] This becomes important as numerous commentaries suggest that without professional indemnity, it would be impossible to protect patients and enforce their rights; and practitioners and establishments will not be able to pay damages awarded by courts.

3.3.3.4 Rule 11: Clinic etiquette

The Code, in its agreeing with the ethics of the medical profession, directs practitioners to offer appropriate privacy to patients,[456] explain their fees and charges,[457] give unconditional positive regard to patients and show empathy.[458] The rule of privacy for patients appears in a few of the Nigerian statutes addressed including the Constitution. However, it has become impracticable because of the limited number of healthcare practitioners, health facilities and the lack of chaperones which promote privacy, and standard medical equipment. A major overhaul of the health system will be required to offer appropriate privacy to patients, especially in the public health sector.

The explanation of fees and charges is one of the rights which patients are unaware of. This is because the position that most patients find themselves in does not empower them to question the practitioners, as their major concern is getting well and leaving the healthcare facility.

455 The Code Rule 10(f).
456 The Code Rule 11(a).
457 The Code Rule 11(b).
458 The Code Rule 11(c).

In addition, the duty to give regard and show empathy can hardly be demanded as these qualities are personal and private and cannot be insisted upon. The continuous education of patients and practitioners as to their rights and duties will persuade both parties to embrace mutual respect and empathy.

3.3.3.5 Rule 19: Informed Consent

Informed consent is differentiated from consent in some cases and texts. The Code specifically identifies with the doctrine of informed consent. It instructs practitioners to obtain consent for invasive and non-invasive procedures, for surgical and diagnostic procedures and directs that consent forms must be printed or written as part of the case note of the patient, with the name of the health establishment boldly written on it. This is not the usual practice in most Nigerian health facilities. It is also striking that there are only a few groups of people who read terms and conditions of contracts and agreements, even if it affects their health. This suggests that there will be few people or patients who will bother to get to know the details of a form presented to them at a health facility, especially where there is an element of trust in the doctor-patient relationship. The Code attempts to protect patients by ensuring that consent should not be restricted to invasive procedures but also to non-invasive procedures, as non-invasive procedures are often overlooked and assumed as inferred.[459]

The Code directs that explanations given before consent is sought must be "simple, concise and unambiguous". Patient counselling must take place before the signing of consent forms, however, the level of illiteracy, language barriers in a heterogeneous society, the lack of interpreters, the number of patients on waiting lists and the inadequacy of practitioners, make it nearly impossible for patients to obtain these explanations before consent is given. This places the responsibility on practitioners and health establishments to engage translators and interpreters, and for government policies to accommodate the importance of having adequate resources and personnel for the realization of patients' rights protection.[460]

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459 The Code Rule 23 directs that donors in assisted conception must receive counselling and give consent.

460 The Code Rule 19.

Although there are no known cases of court orders directing treatment in Nigeria, the Code provides for patients who are below the age of 18, unconscious or with a mental impairment. The court may in such cases give an order for life saving treatment on request of the health practitioner or establishment. The highest-ranking doctor in an establishment can also give the directive to proceed with treatment; however, this is only where the next of kin's decision is not in the best interest of the patient or is contested by the practitioner.

It is also imperative to note that although the Code requires clear and concise explanations before consent is given by a patient, it stipulates in this rule that where the procedure is an irreversible one or difficult to reverse, there shall be three counselling sessions with an interval of four weeks, if the clinical situation permits, to enable the patient to have ample time to make an informed decision and sign the consent form. The consent form must also be signed by witnesses who are present.[461]

The rule in emphatically upholding informed consent on printed forms states, "the voluntary self-offer for professional care by the patient to the practitioner is an expression of consent coming from the patient. The profession insists that certain interactions deserve specific and expressly defined and documented forms of consent".[462] The Code under this rule also acknowledges that there was no standard form for obtaining consent in Nigeria prior to the Code. However, by the institution of the Code, a simple format for guidance as it is referred to, is attached to the Code for universal application throughout Nigeria, declaring other formats for obtaining consent in Nigeria, illegal. The standard form served as a starting point for establishments who, prior to the operation of the Code, had no standard format or procedure for obtaining consent; but the form is also flawed because it does not capture all the requirements of informed consent. Remarkably, the Code outlaws any other form for obtaining consent, some of which may be more detailed, protecting both patient and practitioner.

It is shocking that the suggested form for consent in the Code is not in use in most medical facilities; the researcher has not come across any in relating with,

461 The Code Rule 19.
462 The Code Rule 19(4).

working at, visiting and being treated at healthcare facilities in Nigeria. It is evident that the mere signing of a consent form will not be enough, as consent must be clear to the patient for it to be deemed as informed consent.

The Code states that screening for somatic abnormalities must not be contrary to the patient's interest and the patient must be sufficiently informed of possible outcomes pre-screening. This is because the results of these screenings on a patient and their relatives can attract exorbitant medical, social and financial consequences. These screenings, according to the Code, include screening for HIV and AIDS, genetic determination and cancer, among others.[463] It is believed that pre-test counselling and post-test counselling can prepare the minds of patients before testing and prevent them from losing their dignity.

The Code also stipulates that patients who are required to consent to medical research must have clear information; they must be conversant with terms in the consent form, know about possible risks and benefits, have enough time to make a decision and give the consent in writing. Furthermore, the research must have been approved by a research ethics committee.[464] The popular *Pfizer* case[465] in Nigeria, emphasizes the need for due diligence with medical research, especially with new drugs and treatment. The patient must be the greatest beneficiary of any research, as any attempt to use patients in medical research against their interest is an infringement on their fundamental right to human dignity.

3.3.3.6 Rule 20: Termination of services by patient.

The Code upholds the right of a patient to refuse medical treatment by terminating medical service against medical advice, either personally or by their competent relatives. The Code provides that where the patient alters or reviews his/her decision, treatment should be restored without prejudice. Patients refusing treatment who are not fit to make medical decisions, like paediatric patients[466] and patients below eighteen whose parents are members of a religious sect,[467] are protected by the Code. Practitioners are directed to take positive steps to

463 The Code Rule 19(a).
464 The Code Rule 19(b).
465 2005 U. S. Dist. LEXIS 16126.
466 The Code Rule 20(a).
467 The Code Rule 20(b).

apply treatment and save their lives. The same goes for adult members of religious sects who are without a card,[468] stating their advanced medical decision or religious standpoint and are brought to a medical facility, unconscious.

Although patients may refuse medical treatment, the doctor should not terminate life actively, as it is against the Code which underscores the Physician's Oath to preserve life. The Code is breached when a doctor terminates the life of a patient by administration or prescription of drugs, even at the explicit request of the patient.[469] A doctor will also be in breach of the Code if (s)he terminates life without the patient's explicit request, thinking such action to be in the best interest of the patient.[470]

3.3.3.7 Rule 24: Management of HIV/AIDS and other socially dreaded infectious diseases.

The Code attempts to protect patients from discrimination, by stating that practitioners should not discriminate against patients with "hazardous and contagious ailments." The Code states that their confidentiality must be maintained, and referral must only be based on professional competence. It is, however, notable that the heading for this rule is somewhat discriminatory – "Management of HIV/AIDs and other socially dreaded diseases." It is believed that this heading misconstrues and wrongly categorizes HIV and is not inclusive enough for a code aimed at protecting patients and directing practitioners.

The Code defends its anti-discriminatory posture by stating that practitioners must ensure they are not used by employers to make patients lose their jobs when there is no clinical indication to deny them their jobs, taking into consideration the psychological and social consequences of HIV and AIDS, Hepatitis B, Lassa fever and Ebola fever. The Code was formulated before the Ebola Virus ravaged Nigeria after Mr. Patrick Sawyer from Liberia travelled to Nigeria and fatally infected health workers, especially the treating doctor, Dr Stella Adadevoh.[471] It is believed that with a review of this Code, the Ebola Virus

468 The Code Rule 20(c).
469 The Code Rule 68(a).
470 The Code Rule 68(b).
471 Ross W "Ebola crisis: how Nigeria Dr Adadevoh fought the virus" https://www.bbc.com/news/world-africa-29696011 (Date of use: 10 July 2019).

Disease will not be categorized with HIV, AIDS, Hepatitis or Lassa fever as being the same, and patients will not be discriminated against. Nevertheless, practitioners and other patients will not be put at risk of communicable or infectious diseases.

3.3.3.8 Rule 28: Professional negligence.

This rule emphasizes the duty of care which practitioners owe their patients. It, however, further orders that practitioners shall see and attend to all patients on admission under their care as frequently as the patients' conditions demand.[472] The usual practice is to conduct ward rounds in most health facilities either in the mornings or at specific times; and have a nurse or other healthcare worker monitor the patients and call on a doctor in case of an emergency. The Code's directive of attending to patients as their condition demands is an admirable idea and would be great support for the right to care, health and dignity of patients. However, this rule is only in the Code but not in practice, as there are numerous reports of patients who were abandoned in sick beds and left to suffer in pain and agony, either due to lack of personnel, resources or the inhumanity and negligence of the health workers concerned.

3.3.3.9 Rule 31: Rules guiding physicians in biomedical research involving human subjects.

The Declaration of Helsinki, which was adopted by the World Medical Assembly (hereafter "WMA") in June 1994 and fully at the 48th General Assembly in Somerset West, Republic of South Africa in October 1996, protects the rights of patients as human subjects in bio-medical research. The Code adopted the declaration and is represented in this rule. The Rule protects patients, stating that they must give consent to bio-medical research;[473] such consent should preferably be in writing[474] and must align with national legal guidance.[475]

The dignity of the patient must also be upheld and his/her privacy protected.[476] In the case of patients who are mentally incapacitated and unable to make

472 The Code Rule 28.
473 The Code Rule 31 (A) (ii).
474 The Code Rule 31(A) (viii).
475 The Code Rule 31(A)(X).
476 The Code Rule 31(A)(v).

medical decisions, consent from the "responsible relative" will be required and will suffice.[477] The rule further states that the patient must be guaranteed the best proven diagnostic and therapeutic method; and his/her refusal to participate in medical research should not strain his/her relationship with the doctor.[478]

The *Pfizer* case in Nigeria[479] has explicitly shown the challenges encountered with medical research with human subjects. It is expected that the lessons learnt from the case would embolden research ethics committees and governments to ensure that the Code and the entire content of the Declaration of Helsinki are followed to the letter. Persons who live below the poverty line must be protected by government and the medical profession as hunger, illiteracy, and poverty make human subjects vulnerable to unethical researchers.

3.3.3.10 Rule 34: Deceit of patient to extort fees and service charges.

Although patients are to be given the best care by health practitioners, the Code warns against the detention of patients in hospitals for "ghost procedures" and undertaking medical investigations to increase the practitioners' fees, charges, and earnings. Doing this will be deemed as malpractice.[480]

3.3.3.11 Rule 39: Clinical management of religious adherents.

The Code, in a bid to protect all categories of patients, stipulates clinical management procedures for religious adherents. The Code stipulates that the practitioner must abide by the Hippocratic Oath,[481] acknowledging the right of patients to refuse medical treatment or a mode of treatment. Practitioners must, however, record patients' views about their refusal or acceptance of treatment in medical notes, and it must be witnessed by other persons. This category of patients is also protected within the right to be referred, where the practitioner handling the patient cannot plan optimal care.[482]

The Code categorizes persons between the ages of sixteen and eighteen as able to make personal decisions which override that of their parents; in emergency

477 The Code Rule 31(A)(xi).
478 The Code Rule 31(B)(ii).
479 *Zango v. Pfizer International* [2001] Suit No. FHC/K/CS/204/2001.
480 The Code Rule 34.
481 The Code Rule 39(A)(i).
482 The Code Rule 39(A)(iii).

medical situations, they will be treated without parental consent.[483] Persons between thirteen and sixteen years will be tested based on their "Gillick" competence and acceptable consent standard, to determine whether they can make a valid decision, especially with refusing medical treatment as it is with religious adherents.[484] For persons below thirteen years, where the parent of the patient has refused treatment on their behalf on the basis of their religious leaning, the practitioner is expected to approach the court and get a court order authorizing treatment in the best interest of the patient or granting the requests of the parent.[485]

For unconscious patients, the rule is that they should be searched for "Do Not Resuscitate Order" cards, "No Blood" cards or any verifiable information showing their religious posture; where no such evidence is found, the duty of the practitioner is to save lives. The practitioner may require the order of a court for a longer intervention on behalf of the patient.[486]

As lofty as this rule is, its practicality is yet to be established. Court orders required to protect the patient cannot be as easily gotten as speculated. Obtaining a court order from Nigerian courts as at the time of this research, might take months or longer, and the aim of a court order either to protect a patient by enforcing his/her refusal of medical treatment, or by protecting his/her best interest with a continued treatment order, may have been overtaken by events.

3.3.3.12 Rules 41 and 42: Case referrals to colleagues, movement of patients among practitioners

Although the Patients' Bill of Rights mentions the right to a seamless transition of patients between establishments, the Code explicitly provides that based on the limitation of skill and resources, practitioners must be willing and able to refer their patients to equipped hospitals and more qualified practitioners, as refusal to refer, where it would be in the interest of the patient, would be seen as misconduct.[487] The referral must, however, be managed properly as the

483 The Code Rule 39(C)(i).
484 The Code Rule 39(c)(ii).
485 The Code Rule 39(c)(iii).
486 The Code Rule 39(D).
487 The Code Rule 41(a).

consultant the patient is referred to must not take over the treatment of the patient[488] and must therefore, send a comprehensive report on the patient to the referring doctor; failure to do so will be regarded as misconduct.[489] Patients may also desire a withdrawal of service by a practitioner; however, practitioners must only withdraw their services for good cause, with due notice to patients, allowing them to find another doctor and claim fees paid which were not earned.[490]

Referrals are common within the Nigerian medical sphere. One of the challenges with referrals currently is that doctors in government practice refer patients to their private practice or colleagues in private healthcare for profit. This goes on unchallenged and restricts the right to healthcare for patients who are unable to afford private healthcare. Rule 42 establishes that the best interest of the patient must be the motivation of any transfer of patients and the transfer must be voluntary and conscientious in a decorous, orderly manner.[491] The rule also affirms that doctors must not entice patients to their own practice.[492]

In emergency situations, patients may be seen by other doctors without the permission of their doctor and that would not be deemed as misconduct.[493] The rule further emphasizes the need for case notes and patient history, for continuity of treatment in the interest of the patient.[494]

3.3.3.13 Rule 44: Confidentiality.

The Code accentuates the importance of professional secrecy. It stipulates that any information that comes to the knowledge of practitioners in their relationship of trust with patients is secret and privileged information, which must not be divulged. The exceptions are where the patient consents to divulge the information especially in writing; it is of public interest expressly to protect the patient or the community; and statutory notification of a disease requires it of the medical practitioner. This discretionary breach does not extend to criminal

488 The Code Rule 41(b).
489 The Code Rule 41(c).
490 The Code Rule 45.
491 The Code Rule 42(a).
492 The Code Rule 42(b).
493 The Code Rule 42(c).
494 The Code Rule 42(d).

abortion, a venereal disease, drug dependence, an attempted suicide, or a concealed birth. The patient is protected in these situations.

In practice, there is insufficient monitoring of patient confidentiality because failed systems make confidentiality the least of their worries among persons who are ill and poor. According to the Code, disclosure and breach of a patient's right to confidentiality may be for education, research, monitoring, epidemiology, public health surveillance, clinical audit, administration and planning. Such information should be anonymized, with the consent of the patient. Hospital records are not protected as any person may have access to them without much consequence.

The doctor is directed by the Code to protect the confidentiality of the patient, even after (s)he might have changed employment. This implies that a change of place of work or establishment does not grant a practitioner the capacity to breach patient confidentiality. The duty to keep confidentiality does not only lie with doctors but also with all members of staff in a healthcare establishment; and this duty outlasts the life of the patient as (s)he is to be protected even after death. The doctor is permitted by the Code to disclose, in some circumstances, information which may include where (s)he is accused by a patient for wrongdoing. The doctor may disclose information with regards to the accusation or where the patient intends to commit a crime.

Practitioners must adhere to the ethics of protecting patients' right to confidentiality by painstakingly protecting their medical records.[495] Information may only be released following a patient's informed consent.[496] It may also be used if it is crypt or anonymized data used for teaching or publication in medical journals.[497] The right to confidentiality may be varied according to this rule based on an order of court,[498] a best interest attempt to protect the community from danger or a presentation at a scientific meeting.[499]

3.3.3.14 Rule 67: Torture

495 The Code Rule 44(a).
496 The Code Rule 44(b).
497 The Code Rule 44(c).
498 The Code Rule 44(h).
499 The Code Rule 44(i).

Torture, according to the Code, may be physical, biological and chemical or psychological. The Code protects patients from all forms of torture by imposing a duty on practitioners not to apply torture, condone or participate in any inhuman procedure. The Code describes physical torture as: the systematic beating, flogging, clubbing, punching, slapping, suspension of body frames in unusual positions, sexual torture which includes rape, mutilation of sexual parts and plunging objects into body orifices. It also includes banging of a victim's head against the wall, hair pulling, prolonged standing, mock executions and shooting of body parts, electrical stimulation, drowning, lights aggression and climatic stress in extreme heat and cold, among other things. Biological or chemical torture, according to the Code, can be in the form of misuse of unapproved drugs, forced urine or excrement application, sleep deprivation or tear- gassing. Psychological torture can be in the form of threat to self and loved ones, sexual violations, forced witnessing of the torture of others, deprivation of healthcare comfort to victims or their relatives, among other such manifestations.

Although the Nigerian Constitution guarantees a right to freedom from torture, reports exist of healthcare workers in Nigeria who carry out physical torture on patients, infringing on their rights to human dignity by slapping, systematic beating, hair pulling, prolonged standing, verbal abuse and insults, among others.[500] This explains the detail with which the Code describes the various forms of torture. Monitoring and enforcement of patients' right to freedom from torture as underlined by the Code could restore patients' dignity.

3.3.3.15 Rule 70: Enforcement of sanctions.

The Code is not a mere advisory guide, as infractions may lead to sanctions. The Investigating Panel of the Medical and Dental Council of Nigeria and Disciplinary Tribunal are saddled with investigations and eventual trials, respectively. When they arrive at a conclusion on a matter, the Registrar of the Medical Council shall cause the sentence pronounced to be published in a government publication and as a paid advert in four national dailies. The pronouncement shall also be deposited at the Federal and State Ministries of Health, the Nigerian Medical

500 https://core.ac.uk/download/pdf/82430688.pdf (Date of use: 14 May 2020).

Association or Nigerian Dental Association, depending on which association the practitioner belongs to.[501]

A suspended practitioner shall ensure that he completes a *pro forma* monthly report showing his compliance with the sentence until the expiration of the suspension. This provision, although intended to protect the patient and notify the public of erring practitioners, has not been adhered to as there is no record, for the past ten years, of any paid adverts of decisions of the Tribunal. Also, the Tribunal has not had any disciplinary sitting in about three years, despite numerous petitions before the investigating panel for bureaucratic reasons.

Also, while most rules in the Code were created according to global best practice, the reality in the country has nullified the effect because monitoring, enforcement and supervision have been impossible. There is, therefore, the need to intensify the implementation of the rules of the Code for the benefit of the patients. Also, some sections in the Code have been worn-out by age, others – as identified in the argument above – are flawed with lacunae in favour of infringing medical practitioners, hence, the pressing need for a review of the Code and a statutory time frame for subsequent amendments**.**

3.4 Case law on patients' rights in Nigeria

Having considered existing legislative framework defining and securing patients' rights in Nigeria, there is a need to test their application over the years in order to determine whether they have provided enough protection or there is a dire need for the review of these laws. To do this, I shall highlight reported cases on the protection of the rights of patients in Nigeria below.

3.4.1 Dr. Emmanuel Denloye v. Medical and Dental Practitioners Committee (1968) 1 All NLR 306

This case was an appeal against a decision of the Medical and Dental Practitioners Tribunal. The Tribunal tried the appellant for negligence and for extorting thirty (30) guineas from the patient's father before treating her. Sadly,

501 The Code Rule 70(a).

the substance of the matter, being the rights of the patient, was neglected because the Court found that all evidence against the appellant were procured in contravention of proper procedure as provided for in the instrument which set up the tribunal. Hence, the decision of the Tribunal was annulled because of the contravention of laws of procedure and evidence at trial stage.

This decision brings to the fore the obstacles an aggrieved patient may have to surmount in a bid to get redress or justice. While the patient may have a valid grievance, (s)he may not get justice or redress if the trial is not done according to laid down procedures. This amounts to unfairness against an already aggrieved patient or the family, where the patient is dead. It is also a waste of resources by said patients and a loophole for erring medical practitioners to adopt to avoid liability no matter their actual status of guilt.

3.4.2 Dr. Robert O. Akintade v. Chairman MDPT [2005] 9 NWLR 338-361[502]

In this case, Mrs. Florence Olusola Abe who was at the time of the case, deceased, was on 27 October 1997, admitted at a healthcare establishment called the Christian Health Centre Ilesha, Nigeria for an appendectomy which was carried out by Dr. Robert Akintade, the appellant in this case. There were complications with the operation and deterioration in the patient's health from October 31 to November 4 when the doctor referred her to the Obafemi Awolowo University Teaching Hospital, Ile-Ife, Nigeria where she passed away on November 6, 1997. Her death certificate indicated that an above-knee-amputation was the primary cause of death and septicemia was the secondary cause. The death certificate further indicated that "death in this instance could be attributed to a combination of septicemia following a fecal peritonitis fistula that followed the appendectomy she had in a private hospital. The uncontrolled diabetes and obesity probably also contributed."[503]

The doctor was arraigned before the Medical and Dental Practitioners Tribunal and faced the tribunal on two charges; the first stating that he was negligent by failing to attend to the patient promptly, he was incompetent in his assessment of

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502 *Dr Robert O Akintade v Chairman, Medical and Dental Practitioners Disciplinary Tribunal* [2005] 9NWLR 340 (hereafter "*Akintade v Chairman MDPT*").

503 *Akintade v Chairman MDPT.*

the patient and made errors in pre-operative, operative and post-operative procedures, thereby contravening rules 10(a),(b),(c) and (e) of the Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria and punishable under section 16 of the Medical and Dental Practitioners Act.[504] Secondly, he was alleged to have attended to the deceased in a manner amounting to professional malpractice by admitting her knowing he (the doctor) did not have the required facilities for the treatment, and by failing to refer her earlier to a better facility when the complications set in post-operation, thereby contravening rules 11 and 15 of the Rules of Professional Conduct for Medical and Dental Practitioners.

The doctor was found guilty of an incompetent assessment for failing to diagnose her as a diabetic and not realizing she had post-operative fecal peritonitis. He also made avoidable mistakes by taking an inadequate medical history from the patient; he followed inadequate pre-operative procedures; he applied deficient operative procedures; and he used faulty post-operative management. He was sentenced to a six months suspension which was to commence on the day the Tribunal arrived at a decision. Although he was acquitted on the other charges, he contested the Tribunal's decision, hence, the matter was brought to the Court of Appeal.

The four issues for determination on appeal were – firstly, whether the judgment was borne out of the evidence before the Tribunal, considering the matter was more criminal in nature than civil and there was therefore the need for proof beyond reasonable doubt; secondly, whether by pronouncing on all issues before it, the Tribunal did miscarry justice; the third issue was whether the Tribunal was right to reject the expert's opinion on the postulation of blood sugar without an alternative counter opinion from another expert; and the last issue was whether the doctor was wrong to have carried out the operation on the deceased.[505]

On whether the doctor was negligent for not diagnosing the patient of diabetes, the Court stated that the doctor mentioned in his testimony that he relied on the patient's words and he had no reagent for the diabetes test in his hospital

504 Medical and Dental Practitioners Act Cap 221 Laws of the Federation of Nigeria 1990.
505 *Akintade v Chairman MDPT* [2005] 9NWLR 349 paragraph E-H.

laboratory, and that the treatment was an emergency. The appeal court ruled that the Tribunal was in a good position to assess all facts and the Tribunal's decision was based on the evidence before it. In addition, the court clarified that while the doctor claimed the proof had to be beyond reasonable doubt as in criminal matters, the trial at the Tribunal was not a criminal trial but was for professional misconduct, as the Tribunal was not empowered to try criminal offences. The court also rejected the defence that the surgery was done in an emergency, as the expert evidence did not corroborate it and the patient had travelled for about three hours to see the doctor, left to see her son, and then returned for treatment. Thus, the surgery was an elective one.[506]

On whether he was negligent for not detecting fecal peritonitis early and planning appropriate treatment, the court held that there was no evidence before the Tribunal to justify this charge. The court held that although the Tribunal consisted of qualified medical professionals, their experience cannot substitute or replace evidence and their opinion can only be used to assess the evidence before it and give probative value to it. The appeal was upheld.

Since the sentence by the Tribunal was a three-month suspension each for both convictions, the suspension was reduced to a period of three months only by the court.[507] In a similar case of *Milam v Medical Practitioners Investigation Panel & Anor (2018) LPELR-45539 (CA)*, the appellant was found culpable of professional incompetence in the assessment of a patient; making an incorrect diagnosis particularly when the clinical features were so glaring that a reasonable skilful practitioner could not have failed to notice them thereby performing the operation of bilateral tubal ligation which was not justified.[508]

3.4.3 Okonkwo v MDPT (2001) 7 NWLR (Pt711) 206

In this case, Mrs Martha Okorie and her husband who both belonged to the Jehovah Witness Christian sect and followed the teachings in Leviticus 17:10-11 and Acts 5:29 of the Holy Bible which forbid them from taking a blood transfusion, birthed a baby. The baby was delivered at a maternity ward on July 29, 1991.

506 *Akintade v Chairman MDPT* [2005] 9NWLR 355-6.
507 *Akintade v Chairman MDPT* [2005] 9NWLR 357-9.
508 *Milam v Medical Practitioners Investigation Panel & Anor (2018) LPELR-45539 (CA)*

The mother was admitted at Kenayo Specialist Hospital from August 8 to August 17, 1991 having complained of being unable to walk and severe pain in her pubic area. A day after her admission, a blood transfusion was prescribed. The patient refused to give consent and the doctor discharged her with a statement that despite explanations of the morbidity of her condition, she refused consent to the prescribed treatment.[509]

Upon discharge, she was taken to the Jeno Hospital by her husband. He gave the doctor a card entitled “medical directive/release”, directing that no blood transfusion be given to the patient including where it was vital to life, noting that the patient would, however, accept non-blood expanders. The directive stated the age of the patient and the rationale for the decision and released all practitioners from any consequence of her refusal of a blood transfusion. The patient’s husband also wrote and signed a document entitled “release from liability” with similar information detailing the refusal of a blood transfusion.

The practitioner, Dr. Okonkwo, treated the patient without transfusing blood but the patient died on 22 August. He was then charged before the Medical and Dental Practitioners Tribunal in 1993 on two counts. Firstly, attending to a patient in a negligent manner and thereby conducting himself infamously in a professional respect contrary to medical ethics, punishable under section 16 of the Medical and Dental Practitioners Act. Secondly, he was charged for acting contrary to his oath as a medical practitioner.

On the first count, the charge highlighted that although there was a referral letter from the Kenayo Specialist Hospital which stated the patient was anaemic, the doctor made no plans to and failed to transfuse blood to the patient. Though the doctor claimed inhibition, he was accused of not transferring her to a bigger centre where the said inhibition would not be to the patient’s disadvantage. In relation to the second count, the doctor was accused of refusing to transfuse the patient because of his (the doctor’s) religious belief even though the patient’s relatives pleaded with him to the contrary.[510]

509 *MDPDT v Okonkwo* (2001) 7NWLR (pt. 711).
510 *MDPDT v Okonkwo* (2001) 7NWLR (pt. 711) 200.

The doctor pleaded not guilty at the Tribunal, explaining how he would have preferred to transfer the patient, but her husband said they preferred to abide by his expertise, hence, the signing of a release of liability for him (the doctor) and the hospital. Witnesses against the doctor and complainants in the case included the uncle and mother of the patient. The doctor also stated he would have given a blood transfusion, had the patient consented to it and that he only agreed with their right to make medical decisions and the plea not to be transferred.

The Tribunal's decision was premised on the doctor's refusal to administer a lifesaving treatment in the form of a blood transfusion. The Tribunal also concerned itself with the supposed interference of religion between the patient and her doctor. They deemed it to be against the practitioner's Code of Ethics. According to the Tribunal, when there is a dilemma, the doctor is expected to transfer the patient to where life may be preserved. The Tribunal concluded in its findings that the doctor was not criticized for his personal belief (as he was a Jehovah's Witness himself) or his respect for the patient's religious belief, but for his keeping the patient at a hospital when he knew the correct treatment could not be given there.[511]

He was suspended for six months on three grounds and the suspension was to run concurrently. The doctor appealed this decision. The three issues raised at the appeal were: firstly, whether the allegations in his charge before the Tribunal were criminal in nature, hence, not in the purview of the Tribunal; secondly, whether a failure to allege in the charge that the conduct of the doctor breached a specific part of the Rules of Professional Conduct affected the validity of the charge; and lastly, whether the Tribunal should have found the doctor guilty when it was obvious that the patient and her husband refused to give consent to a blood transfusion.

The Court of Appeal held that death by negligence was a criminal matter and therefore, out of the jurisdiction of the Tribunal. The Court also held that a failure to charge the doctor with a violation of the rules was fatal to the charge and to the possibility finding the doctor guilty. It held that the Tribunal deviated, as the Code of Ethics did not address patients' right to refuse treatment and there was

511 *MDPDT v Okonkwo* (2001) 7NWLR (pt. 711) 205.

thus, no guidance for the doctor. The Court, relying on *Malette v. Shulman*[512] and *Sidaway v. Board of Governors of Royal Bethlehem Hospital,*[513] held that the Tribunal was in error and its decision was overturned.

The Tribunal, unsatisfied with the decision, appealed further to the Supreme Court. The Supreme Court confirmed the decision of the Court of Appeal, relying on *Denloye v MDPT*,[514] sections 303 and 343 of the Criminal Code, *Garba v University of Maiduguri*[515] and *Sokefun v Akinyemi*.[516] The Supreme Court held that the Tribunal's jurisdiction did not cover criminal matters and that the Court of Appeal was wrong in stating that the charge was defective, although it was right in holding that the measures the doctor should have taken in such a dilemma was not stated in the Code of Conduct. The Court further agreed that patient's right to refuse medical treatment is constitutional and the Tribunal was right to accept the patient's right to hold her religious belief, but the Tribunal erred when it did not acknowledge the right of the patient to refuse treatment or blood on those same religious grounds.

The Supreme Court held further that the Tribunal came to a wrong conclusion by its misplacing emphasis on the respondent, Dr Okonkwo's belief rather than the patient's belief. It also held that infamous conduct must be conduct which is reprehensible and disreputable and the doctor did not evidence such conduct. In its conclusion, the Supreme Court suggested that there should be a focus on legal remedies to be available for objecting competent, adult patients in appropriate cases to submit to life-saving treatment and the practitioner must not be a scapegoat. The decision on the patient's consent should have shifted to the courts and there should have been guidance on the issues. It would be wrong to find a practitioner guilty on an issue where there have been neither rules nor standard practice. The Court of Appeal's decision was upheld, and the appeal to the Supreme Court was dismissed.

512 72 O.R. (2d) 417.
513 [1985] AC 871.
514 S. C. 91/68 [1968] ANLR 298.
515 (1986) 1 NWLR (Pt. 18) 550.
516 (1981) 1 NCLR 135.

The Court in a dictum below, per Ayoola JSC., emphasized the constitutionality of patients' right to refuse medical treatment:

> The patient's constitutional right to object to medical treatment or particularly, as in this case to blood transfusion on religious grounds is founded on fundamental rights protected by the 1979 Constitution as follows: (i) right to privacy: section 34 (ii) right to freedom of thought, conscience and religion: section 35. All these are preserved in section 37 and 38 of the 1999 Constitution respectively. The right to privacy implies a right to protect one's thought, conscience or religious belief and practice from coercive and unjustified intrusion; and one's body from unauthorized invasion. The right to freedom of thought, conscience and religion implies a right not to be prevented, without lawful justification, from choosing the course of one's life, religious belief. The limits of these freedoms, as in all cases, are where they impinge on the rights of others or where they put the welfare of the society or public health in jeopardy. The sum total of the rights of privacy and freedom of thought, conscience or religion which an individual has, put in a nutshell, is that an individual should be let alone to choose a course for his life, unless a clear and compelling overriding state interest justifies the contrary…[517]

3.4.4 Danjuma Tanko v Dr. Rom Okekearu (2002) 9-11 SCNJ 101

The plaintiff in this case sued the defendant, claiming one million Naira (NGN 1 000 000.00) general damages for professional negligence by amputating the middle finger of Danjuma Tanko, who was then a senior secondary school student of the Government Secondary School Nyanya in Abuja, without Tanko's consent or the written consent of his parents. The defendant was found guilty of negligently amputating the plaintiff's left middle finger without the consent of his parents. The High Court awarded a hundred thousand Naira (NGN 100 000.00) in general damages, but the Court of Appeal reduced the award to a sum of fifty thousand Naira (NGN 50 000.00).

This case is significant in Nigeria as it is one of the few cases bordering on informed consent and actions of medical practitioners without duly informing a patient of the choices that exist, as well as the possibility of a patient's refusal of treatment.

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517 Per Ayoola JSC in *MDPDT v Okonkwo* (2001) 7NWLR (pt. 711) 206.

3.4.5 Miss Felicia Osagiede Ojo v Dr. Gharoro & UBTH Management Board (2006) 10 NWLR, pt. 987, 175 SC

On 17 December 1993, the appellant at both the Court of Appeal and Supreme Court and who was the plaintiff at the High Court, Miss Felicia Osagiede Ojo, had a surgical operation for the removal of a growth in her fallopian tube. She had been unable to get pregnant and she had had medical advice that the removal of the growth might aid her ability to get pregnant. A surgical procedure was done by the first respondent, Dr Gharoro, assisted by the third respondent, and the surgical procedure was conducted at the second respondent's hospital, the University of Benin Teaching Hospital.

The case before the trial court was that during the operation, the first and third respondents negligently left a broken needle in the patient's womb, which caused her great pain. She claimed special and general damages against the defendants. The amount she claimed was two million Naira (NGN 2 000 000.00) for the negligent way in which the operation was performed. The appellant did not call any expert witness; she was the only witness in the case. There were three expert witnesses called by the respondents – two medical doctors and a radiologist. The appellant, in her evidence, claimed that following pains and a swollen tummy post-surgery at the defendants' hospital, she was rushed to another hospital (Egharevba Hospital, Benin City) for another surgery which became necessary because of a needle left in her tummy by the respondents.

The appellant, in addition, stated that the medical doctor at the hospital where the surgery to remove the broken needle was performed, recommended that she proceeded to the University College Hospital Ibadan to undergo an exploratory laparotomy under fluoroscopy. She also alleged that other gynaecologists she consulted told her that the way the initial surgery was conducted would not allow her to bear a child. She, however, did not call as witness the doctor who performed the surgical operation or any of the gynaecologists who informed her that she may not be able to bear a child. The lack of an expert witness in this case affected the validity of her claims.

The Court, in ruling on whether there was negligence or not, held that the appellant must satisfy her case on a balance of probability and preponderance of

evidence, which she was unable to do. They, therefore, found no direct evidence of negligence. The Court also mentioned that there was no pleading which described the size of the piece of the needle left in her abdomen *vis-à-vis* a complete surgical needle. There was also no proof to show that a surgical needle could not have been broken if the surgeon was not negligent. These were the factors upon which the appeal was dismissed.

This case would have been a good test case for patients' rights, as the accident or negligence of leaving a surgical needle in the abdomen of the patient infringes on the patients' right to dignity at the least. However, based on technicalities, the case was lost. It was the patient's right to seek redress from the High Court to the Supreme Court. There are facts as to why she was unable to present expert witnesses in a matter which was clearly in need of evidence from medical experts. The cost of engaging an expert and the medical professionals' dragging their feet might have been a crucial factor**.**

3.4.6 Tega Esabunor & Anor v. Dr. Tunde Faweya & Ors (2019) LPELR-46961(SC)

In this suit, the appellant sued the doctor through his mother because when he was a month old, he took ill and the doctor prescribed a blood transfusion for him. However, his mother who was at the time, a Jehovah's Witness, objected to the transfusion on the grounds of her religious belief. Nonetheless, the doctor followed due process, got the police to witness the event and then got a Magistrate Court Order to administer a blood transfusion to the baby. Upon the blood transfusion, the baby recovered and was discharged a few days later but the mother approached the Magistrate Court to dismiss the order upon which the doctor treated the baby. The magistrate ruled that the order had been carried out and was irreversible, so the motion was dismissed. The mother appealed to a High Court and then the Court of Appeal, but both courts of record dismissed her appeal. The case was further appealed to the Supreme Court where the Court made a notable pronouncement relating to medical treatment of a child. The court held,

> it is long settled that an adult who is conscious and in full control of his mental capacity, and of sound mind has the right to either accept or refuse blood (medical treatment). The

hospital has no choice but to respect their patients wishes. All adults have that liberty of choice. This freedom has been exercised in accordance with the rule of law (see section 45 (1) (b) of the Constitution). All adults have the inalienable right to make any choice they may decide to make and to assume consequences. When it involves a child different considerations apply and this is so because a child is incapable of making decisions for himself and the law is duty bound to protect such a person from abuse of his rights as he may grow up and disregard those religious beliefs, it makes no difference if the decision to deny him blood transfusion is made by his parents. See M.D.P.D.T v Okonkwo (2001) 7NWLR (pt. 711) p.206. When a competent parent or one *in loco parentis* refuses blood transfusion or medical treatment for her child on religious grounds, the Court should step in, consider the baby's welfare, i.e. saving the life and the best interest of the child, before a decision is taken. These considerations outweigh religious beliefs of the Jehovah Witness Sect. The decision should be to allow the administration of blood transfusion especially in life threatening situations"[518]

The courts affirmed their role as final arbiter in matters of patients' rights. This approach is relevant to the paternalistic conduct of some doctors because the speed with which the magistrate gave the order which saved the patient's life despite a desire to the contrary, could also work to protect a patient from a negligent medical practitioner, other health workers or family members who may be making decisions for incapacitated patients.

3.4.7 Surgeon Captain C.T. Olowu v. The Nigerian Navy (2011) 18 NWLR pt. 1279

In *Surgeon C.T Olowu's* case, the surgeon, a consultant obstetrician and gynaecologist in the employ of the Nigerian Navy offered his services at the Nigerian Naval Medical Centre, Apapa in Lagos and served there as the commander of the medical centre. An obstetrics patient, Mrs. Joy Bassey, undergoing antenatal care at the medical establishment had a medical history of a previous caesarean section for failed induction of labour and a still birth. She was categorized as a high-risk patient. On 2nd April 1999 she went into labour

518 *Tega Esabunor & Anor v. Dr. Tunde Faweya & Ors (*2019) LPELR-46961(SC) Per Rhodes-Vivour, J.S.C. (Paras.F-A).

and was rushed to the Centre. The nurses received her while the surgeon was not present at the facility.

After some preliminary observations and tests by the Nurses, they found signs indicating complications and notified the surgeon who was the appellant in this case. The surgeon arrived later in the day at about 8 pm, asked questions about the patient's condition but left the medical centre without attending to the patient. On his return at about 11 am the next day, he simply wrote a letter of referral for the patient to be taken to another health facility, the Military Hospital Yaba, in Lagos. The patient at this stage was bleeding profusely from her vagina. A surgical procedure at the other health facility revealed that the baby had been dead for about twenty-four hours and the uterus was ruptured and the dead fetus and the placenta were outside the uterus already. This had been occasioned by the prolonged labour.

The hospital performed an emergency hysterectomy. Unfortunately, the patient had no other children and would be unable to conceive in future due to this procedure. The naval surgeon was then arraigned before a court martial where he was found negligent and it was ordered that his rank be reduced from that of a navy captain to that of a commander, which was to set him back at least four years. The Navy Board affirmed the decision on 16 November 2002.

The surgeon appealed to the Court of Appeal, but his appeal was dismissed. Further appeal to the Supreme Court resulted in an affirmation of the lower court's judgement and a dismissal of the surgeon's appeal, saying the appeal lacked merit and his demotion was upheld**.**

The cases on patients' rights infringements have spanned a period of over half a century. For a country which is yet to celebrate its sixtieth year of independence, it is evident that patients' rights infringement and an attempt at protection have been on the front burner. Apart from few cases where technicalities prevailed over the rights of the patients, the judiciary has been an institution which has tried to uphold patients' rights, in accordance with the relevant laws. Courts serve to protect not only the patients, but the medical practitioners as well. The implication of this is that if more cases were to be transferred to the courts, there would be, to a great measure, the administration of Justice. The limitation of the court is,

therefore, the laws and the transfer of cases to them from the tribunal. However, it is worthy of note that most infringements do not get to court for different reasons. Despite the few that get a hearing in court, only a fraction of those reach the superior courts which record their proceedings in law reports.

The question however is, “have there been mechanisms for the patients to report alleged breaches of rights?” Reporting breach is the first step to redressing same. The answer to this question is SERVICOM and will now be discussed.

3.5 SERVICOM

Upon a presidential directive for an audit of the quality of service delivery by public officers and offices, a report[519] revealed poor quality of service delivery, inaccessibility of the public service, and general apathy of public officers while attending to the public. The report further revealed poor public confidence and a very high incidence of wasting institutional resources. Acting upon this report, a presidential retreat on service delivery was held in 2004. It was attended by the president and heads of government parastatals. This meeting resulted in an initiative called SERVICOM. SERVICOM is an innovation of the federal government with the aim of promoting “effective and efficient service delivery in MDAs[520] to ensure customer satisfaction and to manage the performance-expectation gap between the government and citizens as well as other members of the public, on issues of service delivery.”[521]

This development is laudable and at the outset, the SERVICOM desks were noticeable at public facilities, inclusive of hospitals. The first limitation to this innovation is that it applies only to public institutions. The implication of this is that private owned hospitals are not subject to SERVICOM. Akin to this is that, at the time of conducting this research, they are no longer operational even though the agency still exists. So, while the policy and agency still subsist, their functions

519 https://www.ncc.gov.ng/thecommunicator/index.php?option=com_content&view=article&id=205: intro-to-servicom&catid=23&Itemid=179 (Date of use: 10 July 2019)

520 Ministries, Departments and Agencies of government.

521 http://servicom.gov.ng/our-clinic/about/ (Date of use: 27 September 2018).

are currently of no effect. The return of these desks or optimal functioning of this organization is believed to be advantageous in the protection of patients' rights in Nigeria.

3.6 Patients' rights enforcement in Nigeria

The task of enforcement of patients' right is critical in Nigeria, as the infringement of these rights seems to be the order of the day despite a myriad of laws created to protect patients. The professional bodies and courts are the authorities responsible for creating landmark protection decisions to ensure a clear stance on whether patients' rights are a priority or not. There is a low level of awareness of patients' rights among the populace and as a result, a limited number of demands for these rights. As the poverty capital of the world,[522] although with abundant resources, the people of Nigeria are unable to afford the resources required to insist on redress or compensation for breaches of their rights.

The challenges bedevilling patients' rights enforcement are rooted in a poor policing system; bribery and corruption; favouritism and bureaucracy. It is striking that a paternalistic approach by the healthcare profession and the reverence with which the Nigerian patient adores his/her doctor, are obstacles in the attainment or enforcement of patients' rights. Even the members of the Nigeria Police Force are easily manipulated by the highest bidder. The professional disciplinary bodies do not turn over cases with speed and the complaint mechanisms are inadequate and ineffective in enforcing patients' rights. The level of poverty has made shelter, feeding and clothing the priority for a larger number of citizens as against pursuing the enjoyment of their rights. Only the academic or financial elites proceed to court to enforce their rights or as an alternative travel for medical tourism to developed nations to enjoy their good healthcare facilities.

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522 Kazeem Y "Nigeria has become the poverty capital of the world" https://qz.com/africa/1313380/nigerias-has-the-highest-rate-of-extreme-poverty-globally/ (Date of use: 25 November 2018). See also https://www.vanguardngr.com/2018/06/nigeria-overtakes-india-as-worlds-poverty-capital-report/ (Date of use: 25 November 2018).

To solve the enforcement debacle, the power imbalance in the healthcare system must be realigned to suit patients in Nigeria to enable them make demands for the respect of their rights. The government at all levels must make the work of healthcare professionals less difficult by ensuring that public funds apportioned to the healthcare sector are judiciously used to procure and maintain the required facilities and medical equipment, so that the causes of breaches of patients' rights are not occasioned by the absence of the required work tools. Similarly, the professional bodies and regulatory agencies must deliver on their expected functions and ensure that complaints by patients are decisively dealt with in reasonable time.

The above will restore the confidence of patients in the system that has failed them countless times. The Legal Aid Council, SERVICOM and the FCCPC must also provide pro-bono legal services to indigent patients who wish to pursue patients' rights claims against healthcare establishments and professionals. The claims will also be enforceable and realizable if the Nigerian NHA requirement of indemnity for healthcare practitioners and establishments sees the light of day. If the indemnification requirement is actualized, the negotiations and settlements will be between the insurance companies and the patients in the demand for compensation and claims and may compel doctors to be more careful in the exercise of their duties.

There is no question that all these are needed for adequate protection of patients' rights in Nigeria. The question is, is Nigeria on the right track to correct these looming ills in the protection of patients' rights? In 2018, Nigeria proposed a sector specific legislation, the Patients' Rights Bill, to administer the protection of patients' right in the nation and the modalities for seeking redress. This Bill will be considered below, with a primary aim of determining whether it is the much-needed saviour and security for patients' rights in Nigeria or there is a need for further amendment of the budding legislation.

3.7 Patients' Bill of Rights (Nigeria)

The Patients' Bill of Rights was presented to the public by the CPC, now FCCPC in collaboration with the Federal Ministry of Health and other stakeholders in the

Nigerian healthcare space.[523] The Bill was publicly presented in July 2018, identifying rights that accrue to patients from various existing laws and charters and presenting it as a social contract in the form of a Patients' Right Bill. Salient provisions of the Bill are highlighted below.

3.7.1 Access to information

The Patients' Bill of Rights protects the rights of the patient, "to have access to all relevant information in a language that the patient understands"[524] including complete and accurate information about his/her diagnosis, treatment, prognosis, other procedures and possible outcomes. This right also extends to the patients' right to fully participate in implementing the treatment plan and making decisions.

3.7.2 Patient-related information

The Bill guarantees a right of "access to records" including explicit information about the range and scope of services; and access to records of the identity, skills, and credentials of treating professionals and care providers published by the Federal/State Ministry of Health or other relevant authorities.[525]

3.7.3 Fee-related information

The Bill also guarantees the right of a patient to "full disclosure of cost or estimation of recommended treatment plan services, as well as transparent and itemized billing."[526]

3.7.4 Confidentiality

The Bill further guarantees the right to "privacy and confidentiality of all information and medical records, unless disclosure is vital and in the interest of public health, in accordance with prevailing law".[527] In *Stephen Abatan and*

523 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).
524 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).
525 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).
526 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020)..
527 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020)..

Momodu Awudu,[528] the court stated that "the relationship between a doctor and his patient is one of trust and confidence; a relationship where one has the power and duty to treat and restore the other to mental and physical well-being."

3.7.5 Quality of care

The right of "access to a clean, safe and secure health environment, as well as access to equitable quality care and caregivers irrespective of disability" is protected by the Patients' Bill of Rights.[529] In *Abi v CBN,*[530] it was opined by the court that a wrong diagnosis and administration of drugs, where the side effects compared against the benefits have not been communicated to the patient, may lead to an actionable wrong.

3.7.6 Patient's dignity

A patient, according to the Bill, has a right "to be treated with respect and dignity without prejudice to gender, religion, race, ethnicity, allegation of crimes, geographical location, disability or socio-economic circumstances".[531] Advanced directives and proxy decision making are also provided for by the Bill as it states that, "prior wishes of the patient or in the absence of same, of the next of kin (where legally applicable) are respected to the fullest extent practicable during last offices (at the time of death) including cultural or religious preferences, to the extent consistent with extant laws including coroners laws."[532]

3.7.7 Access to emergency care

As protected in the Act, the Bill guarantees the rights of a patient to "receive urgent, immediate and sufficient intervention and care in the event of an

528 (2001) 9 NWLR (pt. 717) 66.
529 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020)
530 (2012) 3 NWLR (pt. 1286) 1 CA.
531 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).
532 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

emergency, prioritizing such needed attention over other factors including cost and payment, as well as law enforcement and requirements."[533]

3.7.8 Visitation

A noteworthy right the Bill protects is the right of patients to "receive visitors for religious purposes according to the rules and regulations of the facility".[534] Despite this stipulation, many family members and well-wishers have been turned away at healthcare facilities in Nigeria, having been informed that they cannot visit at a time or at all. The Nigerian NHA provides that the health establishments should ensure they publicly state their visitation hours, among other vital information they must present to users and potential visitors.

3.7.9 Patient's refusal of care

Refusal of medical treatment, emphasizing patient autonomy, is contemplated in the Bill by conferring acceptance or refusal of care on the patient. The Bill states that "patients at all times, retain the control of their person and must be informed of their power to decline care upon full disclosure of the consequences of such decisions."[535] In addition, "patients have the right to consent or decline participation in medical research, experimental procedures or clinical trials during treatment."[536]

3.7.10 Interruption of service provider

To create a smooth transition of patients within services, the Bill guarantees the right to "be informed about impending interruption or disengagement of services of primary or attending professionals responsible for a patient's care."[537] This

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533 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

534 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

535 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

536 See also http://www.mondaq.com/Nigeria/x/309372/Life+Sciences+Biotechnology/Balancing+Access+To+Experimental+Drugs+With+The (Date of use: 18 December 2018).

537 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

right also includes a "methodical and practical transition for patients' safety and continuity of care."[538]

3.7.11 Complaints

Importantly and lastly in the Bill is the right of a patient in Nigeria, "to express dissatisfaction regarding service and/or provider, including personnel changes and abuse."[539] This is obviously one of the most important rights in the Bill, as an inability to complain about the infringements will make the rights a façade. It is however unfortunate that there is no complaint mechanism that can achieve the required mollification for patients whose rights have been abused**.**

It is obvious that the contents of this Bill are essentially a re-statement of the status quo. The laudability of the Bill is that it is a codification of all rights that were previously sparsely distributed. The highpoint of the Bill, however, is that it amplifies the right of patients to complain where they are not satisfied with the treatment received in a medical facility or from a medical practitioner. This highlights that the rights of the patients are the major concern of the Bill.

The Bill is, however, not an all patients' rights affair – it also highlights responsibilities of patients including the duty to seek relevant information about the treatment they are receiving; provide requisite information that will aid in their treatment truthfully and wholly; pay medical fees; accord respect to the medical practitioners charged with their care; respect and consider the rights of other patients; as well as comply with the rules and regulations in the medical facility where they are being treated. Another important duty of patients is to complain when care has been unsatisfactory. The dirge in the healthcare sector in Nigeria is because patients have learnt to take such unsatisfactory treatments in good faith, being more grateful for a restored health than injured for breached rights. Where patients are responsive to report medical malpractices of any form, the health sector in Nigeria will be better reformed.

538 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

539 http://fccpc.gov.ng/uploads/files/patients-bill-of-rights-full-version.pdf (Date of use: 14 May 2020).

Like its legislative predecessors, where mechanisms for actualizing the contents of this Bill are underdeveloped or stifled in bureaucratic bottlenecks and red tapes, the protection of patients' rights in Nigeria will remain a mere illusion; a subject of academic discourse, rather than a reality.

3.8 Conclusion

I have examined laudable legislative provisions in this chapter, which is a revelation that to a large extent, patients' rights in Nigeria are accorded legislative and institutional protection. The contents of the Nigerian Constitution, the Nigerian NHA and the Code, are evidence of the attempts to make healthcare in Nigeria responsive to the needs of the patients and the society at large. Medical litigation as well as the proposal of a Patients' Right Bill, is an accentuation of the drive for the attainment of maximum protection of patients' rights in Nigeria. The Federal Government also made further efforts to put in place a means of complaint, albeit in public medical facilities, in the form of SERVICOM.

I have, however, shown above that the prevailing institutional, social and technical flaw in the Nigerian public services, have watered down the enforcement of these laws by the different machineries of government. The unequal distribution of standard basic amenities in the society, the high level of poverty and diseases rates, and poor doctor to patient ratio among other challenges, evoke a deeper need for health and wellness over a demand for rights. The patient is often at the mercy of the standard of healthcare (s)he can afford, hence, is unable to demand for standard patient care (s)he deserves. There is also a continuous need for regulatory agencies, professional bodies as well as civil societies, to update the standard expected of healthcare facilities; defend the rights of patients to be served at the level of the global best practice of healthcare despite the limited resources and prevalent conditions of work in healthcare settings; and serve as a watchman over the administration of healthcare in Nigeria.

Also, although laudable, the Patients' Bill of Rights is but a restatement of what is available, without an attempt to correct the ills that plague the health sector in Nigeria. The implication of this is that, where the existing ills remain unchecked,

the Bill will most likely head towards a certain doom. Proposing definite means of resolution of most, if not all these ills plaguing the health sector as per patients' rights is one of the aims of this research, but the attainment of this aim will be discussed much later in this research. The immediate pursuit, however, will be the examination of the health laws and patients' right protection legislations in the Republic of South Africa and the UK, in that order, from the succeeding chapter.

CHAPTER 4: PATIENTS' RIGHTS IN SOUTH AFRICA: A MULTI-SYSTEM APPROACH AND A RIGHTS- BASED SOCIETY.

4.1 Introduction

In the previous chapter, I examined the protection of patients' rights in Nigeria. I found that the core problem is not just the dearth of legislation to protect the rights of patients but importantly the implementation of the existing laws and ethical code. There is the need to determine if this is a common limitation and if it is, evolve a mechanism to correct same. If it is not, the question then would be: what makes patients' rights protection feasible in other core jurisdictions of this research; and are they adoptable parameters in the Nigerian legal system?

This chapter analyses whether the rights of patients in South Africa are being protected by law. If yes, which laws do so, and to what extent? I consider in this chapter: constitutional protection of patients' rights in South Africa, especially in the Bill of Rights, vis-à-vis constitutional protection in other extant legislation in South Africa such as the SA NHA, the MHCA, the Traditional Health Practitioners Act, the Consumer Protection Act, the SA Charter and several other laws, both domestic and international.[540] The SA Charter is a succinct compilation by the HPCSA to ensure that users[541] of the health service are aware of their rights and responsibilities.[542] The SA Charter also guides healthcare workers, as it is a yardstick against which complaints of misconduct are evaluated.[543] It is worthy of mention that these legislation did not exist hitherto.[544] This is because health was not recognized as a human right in the earlier years under the apartheid government which had determined access to healthcare by race or class. In the new democratic society of South Africa, things have changed significantly

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540 Some of the laws include the Health Professions Act 56 of 1974; The Medical Schemes Act 131 of 1998; The Nursing Act 33 of 2005; Pharmacy Act 53 of 1974; Choice of Termination of Pregnancy Act 92 of 1996 amongst others.

541 A general term used for healthcare subscribers or patients by the NHA.

542 It is believed that the term "user" is to present persons who utilize the health service as people who choose the service and deserve a standard of care, rather than passive recipients. See Section 27 "Rights of vulnerable groups to healthcare" Health and Democracy 283 https://section27.org.za/wp-content/uploads/2010/04/ChapterMDPDT v Okonkwo (2001) 7NWLR (pt. 711) 9.pdf (Date if use: 10 July 2019).

543 SA Charter Introduction at 1.

544 Dhai A "A health system that violates patients' rights to access healthcare" 2012 *SAJBL* 2.

although things are "not yet *uhuru".*[545] The South African healthcare system is still described as a two-tier system divided across economic lines.[546]

I also consider the implication of the breach of these laws, if any,[547] as well as patients' rights protection of persons living with HIV and AIDS, children and prisoners. In this chapter, I use the SA Charter as a guide through the rights of patients and in addition, address some other rights not emphasized in the SA Charter but existing in other laws and ethical codes.[548]

4.2 The Constitution of the Republic of South Africa, 1996 and the Bill of Rights

The Constitution RSA is the supreme law in South Africa. It provides for the rights of citizens in South Africa and all laws must be aligned with the provisions of the Constitution RSA.[549] Some sections of the Constitution RSA are directly linked to patients' rights in healthcare settings, while other rights are general but may be transposed for the purpose of achieving patients' rights protection. Some of the constitutional rights related to patients' rights and healthcare are: the right to have access to healthcare,[550] the right to life,[551] the right to bodily and psychological integrity,[552] the right to privacy,[553] the right to freedom of movement,[554] the right

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545 *Uhuru* is a Swahili word for freedom and "Not yet Uhuru" is the title of Letta Mbulu's song emphasizing that all was not well yet.

546 Young M *Private v Public Healthcare in South Africa* (Honors Thesis Western Michigan University 2016) 3-4.

547 Usually, the liability for breach of the Charter is civil or criminal liability. Carstens PA and Pearmain D *Foundational principles of South African medical law* (LexisNexis Durban 2007) 264.

548 HPCSA Guidelines for Good Practice in Healthcare Professions Booklets 1-16 http://www.hpcsa.co.za/Conduct/Ethics (Date of use: 26 June 2018).

549 *In Pharmaceutical Manufacturers Association of South Africa: In re Ex parte Application of the President of the Republic of South Africa* 2000 (3) BCLR 241 (CC) at 44 it was stated that "There are not two systems of law, each dealing with the same subject matter, each having similar requirements, each operating in its own field with its own highest court. There is only one system of law. It is shaped by the Constitution which is the supreme law, and all law, including the common law, derives from the Constitution and is subject to constitutional control." In *Carmichele v Minister of Safety and Security* 2001 (1) SA 489 (SCA) the court said that "where the common law deviates from the Bill of Rights the courts have an obligation to develop it by removing the deviation". See also McQuoid-Mason DJ "An introduction to aspects of health law: Bioethical principles, human rights and the law" 2008 *SAJBL* 1-4.

550 Constitution RSA s 27.

551 Constitution RSA s 11.

552 Constitution RSA s 12(2).

553 Constitution RSA s 14.

554 Constitution RSA s 21(1).

to religion and belief,[555] the right of access to information[556] and the right to equality and non-discrimination,[557] the right to seek redress in a court of law for rights infringement,[558] among other rights. A few of these rights, as highlighted in sections, are discussed below.

4.2.1 Section 7: Rights.

The Bill of Rights is the "cornerstone of democracy in South Africa".[559] This section states that the rights of citizens are protected by the Bill of Rights, affirming their right to dignity, equality and freedom. This vital section of the Constitution RSA also asserts that, "the state must respect, protect, promote and fulfil the rights in the Bill of Rights." The rights are subject to the limitations in section 36 of the Constitution RSA, which shall be addressed later in this chapter.

4.2.2 Section 8: Application.

The Bill of Rights stipulates that natural or juristic persons are bound by the Bill based on the nature and extent of the right and the duty imposed by such right. Juristic persons are also entitled to the rights in the Bill of Rights to the extent of the nature of the right and that specific juristic person. This suggests in relation to healthcare law that whereas individuals representing healthcare institutions may be culpable, the institution or facility which may be a juristic person is also bound by the Bill. It is important to note that professional indemnity for healthcare workers and the principle of vicarious liability makes medical negligence claims easier rather than expecting the hospital or its staff to pay privately.[560]

4.2.3 Section 9: Equality.

This section emphasizes equality of all before the law and that all have the right of equal protection by the law. The state is prohibited from direct or indirect unfair discrimination on the following grounds or more, " … race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age,

555 Constitution RSA s 15(1).
556 Constitution RSA s 32(1).
557 Constitution RSA s 9.
558 Constitution RSA s 38.
559 Constitution RSA s 7(1).
560 See for example *Oppelt v Head: Health, Department of Health Provincial Administration: Western Cape* [2015] ZACC 33.

disability, religion, conscience, belief, culture, language, and birth".[561] Section 9(4) further commands the legislator to promulgate a national anti-discriminatory law;[562] and section 9(5) states that any discrimination on the basis of the factors listed in section 9(3) is deemed as unfair discrimination, except if it is established as fair.

This section of the Constitution RSA has a strong impact on healthcare delivery, as discrimination is a major factor for consideration in the healthcare system of South Africa based on the apartheid history and the economic divide. The Constitution RSA forbids any discrimination based on race, which many blacks have complained about in South African history as the bane of underdevelopment and the cause of societal imbalance including within the healthcare system.[563] The Constitution RSA also outlaws any discrimination based on sex, gender or sexual orientation. The gender imbalance has historically affected the female gender more,[564] with the need for chaperones, incidences of sexual abuse,[565] imbalance of power and other forms of gender disproportion.

The discussion of discrimination based on sex, gender or sexual orientation will be towards the healthcare system's approach to gays, lesbians, bisexuals and transsexuals. The development of new gender types and categorizations are an emerging discussion in healthcare management but there is insufficient data as to how the South African healthcare system is managing the development. The law states clearly that everyone is equal before the law; hence no one should be discriminated against because of their sexual orientation, except where the discrimination is deemed as fair according to the limitation clause.

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561 Constitution RSA s 9(3).

562 This has been done; see the Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000.

563 Maseko L and Harris B "People-centeredness in health system reform: public perceptions of private and public hospitals in South Africa" 2018 *South African Journal of Occupational Therapy* 22-27.

564 https://greatergood.berkeley.edu/article/item/how_to_address_gender_inequality_in_healthcare (Date of use: 13 May 2020)

565 Cohen C *et al* "Sexual harassment in the physician-patient interaction: analysis of charges against doctors in the state of Sao Paulo" 2009 *Clinics* 1075-1083.

Preference for persons who cannot relate with a culture or way of life in treatment facilities, although it is common practice, might also lead to discrimination as it prevents equality. An example can be found in Montgomery's work on healthcare in South Africa,[566] where mention is made of the Lotus River Primary Hospital, Cape Town where patients would be waiting outside the hospital before its usual 8 am opening time and at opening, every patient must go to a waiting room, four of which were easily filled. The hospital staff would then go to each of the rooms and sing a song called the "Ghoema Song" and whichever patient danced the most won the "golden ticket" and would skip the line to be seen by the doctor first; the winning patient would also get a front-line space at the pharmacy. This method was created to reduce the waiting time for some patients who might not see the doctor fast; however, the singing and dancing lottery might rob some patients who are either not culturally involved or do not understand the dancing or the benefit of winning this golden ticket. A patient who is a foreigner or not integrated into the society and its dance practices may have his/her right to health limited based on a cultural dancing contest.

Other grounds which the Constitution RSA refers to as discriminatory are the grounds of age, disability, religion, conscience, belief, and birth. The right of children to receive medical treatment and make medical decisions is an emotional discussion. The Children's Act,[567] case law, as well as ethical guides have attempted to direct healthcare workers on how to handle specific situations. The elderly in and out of geriatric care also have rights and should not be denied these rights in healthcare settings because of their age or incapacity.

Disability can also be a ground for discrimination in healthcare. The rights of a disabled patient can be infringed upon by the location of the health facility or the physical restrictions required to access health services. For example, a blind patient may be at the mercy of another patient to fill in medical forms or move around in a health facility; or a person without legs or arms may require physical assistance where there is no wheelchair access, such as ramps, in the health facility. This, without doubt, is discriminatory and should be catered for from the

566 Young M *Private v Public Healthcare in South Africa* (Honors Thesis Western Michigan University 2016) 5-6.

567 Act 38 of 2005.

construction of buildings to the administration of healthcare services daily for persons with special needs.

The Immigration Act permits nationals of other countries to receive medical treatment in South Africa for a specific period.[568] It, however, prevents persons who have been infected with certain infectious diseases –regarded as prohibited persons. These diseases may be reviewed from time to time. Some authors have queried the constitutionality of this law, but it is yet to be challenged in court.[569]

4.2.4 Section 10: Human dignity.

"Everyone has inherent dignity and thus has the right to have their dignity respected and protected."[570] The right of a person to have his/her dignity respected is reflected in the patient's rights to informed consent, refusal of treatment, second opinion and continuity of care in the SA Charter. This right also includes the decision of a patient on issues at the beginning and end of life, like abortion and euthanasia.[571] State interest must not overshadow an individual's right to have his/her dignity protected. This right is one of the non-derogable rights, which are entirely protected by the Constitution RSA.

4.2.5 Section 11: Life.

This section is one of the shortest in the Constitution RSA – "everyone has the right to life"[572] – but it protects the most fundamental right of citizens. Patients are also major beneficiaries of this right as no healthcare worker can deliberately end the life of a patient. It is also from the protection of this right to life that many other

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568 The Immigration Act 13 of 2004.

569 Alfaro-Velcamp T "Don't send your sick here to be treated, our own people need it more: immigrants' access to healthcare in South Africa" 2017 *IJMHSC* 56-59.

570 The Constitution RSA s 10. See also Carstens and Pearmain *Foundational Principles* 29. In *S v Makwanyane* 1995 (3) SA 391 (CC) at 451 the court said that: "The importance of dignity as a founding value of the new Constitution cannot be overemphasized. Recognizing a right to dignity is an acknowledgement of the intrinsic worth of human beings: human beings are entitled to be treated as worthy of respect and concern" and (at 507) "The rights to life and dignity are the most important of all human rights, and the source of all other personal rights in chap 3. By committing ourselves to a society founded on the recognition of human rights we are required to value these two rights above all other".

571 *Ex Parte Chairperson of the Constitutional Assembly: In re Certification of the Constitution of the Republic of South Africa* 1996 (4) SA 744 (CC) 59.

572 See Carstens and Pearmain *Foundational Principles* 27 "The government has an obligation to protect the life of everyone in South Africa". *Mahomed v President of the Republic of South Africa (Society for the Abolition of the Death Penalty in South Africa Intervening)* 2001 (3) SA 893 (CC) 917.

rights flows. The protection of the right to access healthcare, a healthy and safe environment, continuity of care, and other similar rights, is to keep the patient alive where it is medically possible to do so with the consent of the patient. The right to life is inalienable and non-derogable. Healthcare workers who have erroneously taken the life of another have faced sanctions by the HPCSA and sometimes criminal proceedings for the infringement of this right.[573]

4.2.6 Section 12: Freedom and security of the person.

This section protects the freedom and security of the person; it is to protect persons from police detention and other forms of detention, torture and degrading treatment. Patients are protected in this section as it prevents arbitrary deprivation of freedom without just cause and prevents treatment in a degrading, inhuman or cruel manner.[574] The section further protects patients from arbitrary detention under the MHCA and other forms of unlawful hospital detentions. A patient is prominently protected in section 12(2) which protects the right to bodily and psychological integrity.[575] The Constitution RSA protects every citizen's right, "to make decisions concerning reproduction", "to security in and control over their body" and "not to be subjected to medical or scientific experiments without their informed consent".[576] This section clearly focuses on the patient and his/her reproductive rights which include abortion, sterilization, surrogacy, and other similar rights.[577]

This section also protects the right of a patient to refuse treatment and the right to informed consent, especially for experimental purposes. This constitutional protection places a premium on these rights, as they not only exist in mere moral codes like the SA Charter and ethical guidelines. These rights, therefore, have the force of law and can be contested in a court of law as a breach of the Constitution RSA when infringed upon.

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573 *Allot v Paterson & Jackson* 1936 SR 221; *S v Berman* 1966 (WLD) (unreported; see also *S v Lombard* 1979 (TPA) (unreported).

574 See Carstens and Pearmain *Foundational Principles* 29-32.

575 See *Minister of Safety and Security v Xaba* 2003 (2) SA 703 (D) and *G v Superintendent, Groote Schuur Hospital* 1993 (2) SA 255 (C).

576 Constitution RSA s 12(2)(c).

577 See Carstens and Pearmain *Foundational Principles* 185.

4.2.7 Section 14: Privacy.

The Constitution RSA protects the right to privacy, including protection from search or seizure of property or possessions.[578] The patient is protected based on this right impliedly. The patient's right to privacy and confidentiality of medical records is attached to his/her right to privacy in the Constitution RSA.[579] The healthcare worker has a duty to ensure that a patient's right to privacy is adequately protected as a constitutional right, underscored by the SA NHA and the SA Charter.

4.2.8 Section 15: Freedom of religion, belief and opinion.

The right to freedom of conscience, religion, thought, belief and opinion is protected by the Constitution RSA in section 15. This right is important in relation to patients' rights because it impliedly gives patients the right to refuse treatment based on their religious beliefs.[580] That a patient has a belief different from that of the healthcare practitioner or an opinion which is deemed as uncommon or even illogical, should not be a ground to deny that patient access to treatment or infringe on his/her right to refuse a form of treatment or refuse treatment totally. This right recognizes the ethical principle of individual autonomy which protects the right of the individual to his/her opinion.

4.2.9 Section 21: Freedom of movement and residence.

The Constitution RSA grants the right of citizens to movement, including leaving the Republic and residing anywhere therein. It is important to note that although this right does not seem intended as a patient right, medical tourism may test its weight, especially where citizens travel out of the country or aid other citizens outside the country to attain a right which would have been deemed against the

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578 Constitution RSA s 14(a-d). See also Carstens and Pearmain *Foundational Principles* 32-33, and also *C V Minister of Correctional Service* 1996 (4) SA 292 (T) and *Seetal v Pravitha NO* 1983 (3) SA 827 (D) where the court stated "Yet a blood test on somebody without his consent is unquestionably an invasion of his privacy. And the invasion is no less such because on just about every occasion the test is otherwise innocuous".

579 See as an example *Tshabalala-Msimang and Another v Makhanya and Others* (18656/07) [2007] ZAGPHC 161; 2008 (6) SA 102 (W); 2008 (3) BCLR 338 (W); [2008] 1 All SA 509 (W) (30 August 2007).

580 See SAMA position on patients' rights to religious freedoms at https://www.samedical.org/links/responsibilities (Date of use: 27 February 2020).

law in South Africa.[581] In the UK case of *Purdy*, Debbie Purdy wanted to die, having been diagnosed with progressive multiple sclerosis. She knew that there would come a time when she would no longer be able to bear it and would want to end her life in a country where it was legal to do so. The challenge was that it would have been impossible for her to do this by herself, and so her husband was willing to help. There was no guideline regulating the support her husband could give her, as it is illegal according to the Suicide Act[582] in the UK to aid and abet or facilitate another person's suicide. The case essentially considered whether the legal limitation in the Suicide Act infringed on her right to privacy and conflicted with Article 8(1) and (2) of the European Convention. The Court of Appeal in the UK stated that it did not, but the European Court of Human Rights stated that it was an interference with her rights in Article 8 and the House of Lords subsequently directed that the director of public prosecutions produce guidelines expatiating the culpability in relation to the Suicide Act as the European Convention was not promulgated with the Suicide Act in mind.[583] A similar situation in South Africa may test the constitutional right of citizens to freedom of movement. The issues may include whether insurance companies will be liable to pay for a health procedure undertaken abroad, which would have been deemed as unlawful had it been undertaken in South Africa.

4.2.10 Section 24: Environment.

The health rights of a patient to a safe environment are protected by this section of the Constitution RSA. It provides for "the right to an environment that is not harmful to a patient's health or wellbeing."[584] This right is a constitutionally guaranteed right but environmental degradation, poverty and ruin, filth, lack of conservation and a life of squalor, makes this section to be a promotion of the ideal and a distant cry from the reality. In some accounts of patients and health workers, some of the health facilities in South Africa have become a reflection of

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581 See the case of *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45.

582 Suicide Act 1961 Chapter 60, 9 and 10 Eliz 2 s 2(1) http://www.legislation.gov.uk/ukpga/Eliz2/9-10/60 (Date of use: 27 June 2018).

583 *R (on the application of) v Director of Public Prosecutions* [2009] UKHL 45 (30 July 2009). http://www.bailii.org/uk/cases/UKHL/2009/45.html per Lord Hope 34, 40 and 53 (Date of use: 27 June 2018).

584 Carstens and Pearmain *Foundational Principles* 33-34.

the society, where dirt and waste have ruined the environment and the citizen, especially the patient, is likely to be worse off than (s)he was before visiting a healthcare facility.[585]

In some public hospitals, best practices are not followed in urine analysis, use of gloves, hand washing, care for bed linens and the use of medical instruments.[586] Montgomery's research on healthcare in Africa revealed that in one of the hospitals, urine cups used for urine analysis were not cleaned after use, as the nurse only poured the urine out after she had dipped the test kit in the urine. It was not rinsed for the next patient with any soap or a sanitary procedure. The nurses also used their bare hands for the strip and did not clean the counter upon which the test strips were placed before being thrown out. This is regarded as a high-risk behaviour and it is suggested that disposable cups for this test or proper sanitization ought to be engaged to protect the right of patients to an environment that is safe for their health. There was also a lack of glove usage and where the nurses did use gloves, they did not change them even when there was a risk of passing infections from one patient to another. The paper also noted that although there were supplies for hand washing in hospitals, a lack of a hand-washing culture was a problem – there was no policy on it and it was thus, optional. Bed linens were also not changed at the end of the day unless there was bodily fluid on it. Montgomery observed that when there was blood on the bed linens they were not changed, but only a paper towel was placed on the bed sheet. This, and other dangerous practices, endanger patients and deprive them of the right to an environment conducive for their wellbeing.[587]

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585 African Charter on Human and Peoples' Rights article 16; the ICESCR article 12 specifically mentions the right to 'health and well-being' which encompasses basic environmental issues leading to failing health such as waste management, environmental pollution amongst other challenges.

586 Young M *Private v Public Healthcare in South Africa* (Honors Thesis Western Michigan University 2016) 5-8.

587 Young M *Private v Public Healthcare in South Africa* (Honors Thesis Western Michigan University 2016) 5-8.

4.2.11 Section 27: Healthcare, food, water and social security.

This section in the Constitution RSA provides that "everyone has the right to have access to healthcare".[588] It also provides for the right to food, water, and social security.[589] Significantly, the Constitution RSA advances the right to emergency medical treatment.[590] The words in this section are carefully crafted and have a decisive role to play in determining what type of right this is. This right does not guarantee healthcare but is a right to have access to healthcare. This suggests, as presented in the case of *Soobramoney,*[591] that although each citizen has this right guaranteed, like most socio-economic rights, this right cannot be enforced. The groupings of the socio-economic rights in the Constitution RSA is seen as deliberate by the drafters to ensure uniformity; hence, the Constitution RSA provides for healthcare, food, water, and social security.[592] Kramer noted that section 27(3) is espoused in the negative, as it states that "no one may be refused emergency medical treatment" instead of "everyone shall receive emergency medical treatment."[593] "The drafters of the Constitution RSA suggested that the right not to be refused emergency medical treatment is an obligation and immediately enforceable",[594] yet certain cases have shown differently. The right of access to healthcare is a pivotal right for patients, especially poor patients, who cannot afford private healthcare and become victims of rejection and long waiting times in public hospitals.

4.2.12 Section 28: Children

In this section, a child is referred to as a person below the age of eighteen years. The Constitution RSA provides every child with the right to "basic nutrition, shelter, basic healthcare, and social services"; it also states that in every matter concerning a child, the best interests of the child will be of paramount

588 The Constitution RSA s 27(1)(a). See also Carstens and Pearmain *Foundational Principles* 34-45.
589 Constitution RSA s 27(1)(b) and (c).
590 Constitution RSA s 27(3).
591 *Soobramoney v Minister of Health KwaZulu-Natal* 1998 (1) SA 765 (CC).
592 Toebes *The Right to Health as a Human Right* 82-83.
593 Kramer EB "No one may be refused emergency medical treatment: ethical dilemmas in South African emergency medicine" 2008 *SAJBL* 55.
594 Kramer 2008 *SAJBL* 55-56.

importance.[595] A child as a patient generates some quandary in medical decision making, especially in reproductive medicine, abortion and the law.[596] The Constitution RSA is clear on this, as it emphasizes the child's best interest as important. The courts in South Africa have aligned with this constitutional provision which is akin to international decisions on medical decisions concerning a child.[597] That the patient is a child does not strip him/her of the capacity to make decisions or deny him/her of access to healthcare, confidentiality or any other rights that an adult patient would be entitled to.[598] There are grey areas, which ethical guidelines and case law direct, but all the decisions must be seen to align with protecting the best interests of the child.[599]

4.2.13 Section 30: Language and culture.

This section grants the right to use language and participate in cultural life; this participation must not conflict with the Bill of Rights. As earlier mentioned, some practices by healthcare practitioners which may be acceptable cultural practices[600] in a certain location and with it, the use of a specific language, can be detrimental to patients who are not members of that socio-cultural group or do not speak that language. This right, although not directly channelled towards patients, must therefore, be read and practiced in consonance with the proviso ensuring that every language and cultural participation do not infringe on the rights of a patient. Although individuals have rights, there must not be an overlap which brings discomfort to the health rights of others.

4.2.14 Section 31: Cultural, religious and linguistic communities.

Directly linked with section 30, section 31 grants the right of persons to practice their culture, their religion and use their language except where it is inconsistent

595 Constitution RSA s 28(2).
596 See Carstens and Pearmain *Foundational Principles* 77-82.
597 See for example *H v Fetal Assessment Centre* [2014] ZACC 34. See also *Hay v B* 2003 (3) SA 492 (W) and *Life Healthcare Group (Pty) Ltd and another v JMS (as parent and guardian of the infant child MT) and another* 34758/2014 [2014] ZAGPJHC (20 October 2014).
598 The Children's Act 38 of 2005.
599 Carstens and Pearmain *Foundational Principles* 115-117.
600 Female genital mutilation is deemed acceptable in some cultures but is deemed harmful to the health of the patient.

with the Bill of Rights.[601] The religious or cultural leaning of a patient must not be a ground to deny that patient of his/her rights as a patient. If the refusal of treatment or medical decision is by a patient who has capacity, such refusal being one not putting the public at risk and not breaching any of the other rights in the Bill of Rights, the patient has a right to enjoy his/her culture, religion and to use his or her own language.

4.2.15 Section 32: Access to information.

This section grants a right of access to information. This right will benefit patients in terms of the right to access medical records. The right is granted for any information held by the state or held by another person required for the protection of rights. This would suggest that where a patient desires to prove that any of his/her other rights have been infringed upon, (s)he can demand the enforcement of his/her rights to his/her medical records, either from a government health facility or from a private hospital or clinic. It is unclear if courts will interpret this section of the Constitution RSA in this manner anytime soon or whether patients will make such demands utilizing this provision.

4.2.16 Section 33: Just administrative action.

This section provides for "just administrative action." This Constitution RSA right has now been legislated in the Promotion of Administrative Justice Act 3 of 2000. The SA Charter also grants a right to make complaints about health services and for those complaints to be addressed and the complainant given some feedback. The constitutional right to just administrative action, grants a right to a fair and reasonable process of assessing administrative complaints, written reasons where rights have been breached and recourse to a court or tribunal.[602] This constitutional provision allows internal administrative mechanisms to settle patients' complaints and where they are handled properly, will reduce the litigation of clinical negligence. It is also suggested that hospitals and medical facilities in general, adopt alternative dispute resolution methods in solving a patient's complaints for effective administration and to assuage aggrieved

601 Constitution RSA s 31(1)(a).
602 Constitution RSA s 33(1 and 2).

patients whose rights might have been affected. The office of the HPCSA Ombudsman and the newly created office of the Health Ombudsman are a clearing house for settling complaints and solving issues without court processes.

4.2.17 Section 34: Access to courts.

In consonance with Section 33, the Constitution RSA grants the right of access to courts, a tribunal or forum for the resolution of disputes. Patients can approach courts of law for the enforcement of their rights, as they are enshrined in the Constitution RSA. It is recommended that special courts be established to address medico-legal issues based on the expertise and speed required in dispute resolution. A patient who wishes to enforce his/her right to refuse treatment might not have months to wait for a hearing date in court; furthermore, decisions of informed consent or access to healthcare may require instant directives of courts or tribunals. This suggests that a specialized court, with the use of technological advancements, can make swift decisions either physically in chambers, at a *locus in quo* or via modern methods of technological development like video calling, video conferencing by Skype, WhatsApp,[603] or any other available medium. This will add weight to give bite to the rights of patients especially where time is of the essence.[604]

4.2.18 Section 35: Arrested, detained and accused persons.

The rights of persons arrested, detained and accused are protected by the Constitution RSA in this section.[605] Of particular importance to patients' rights here, is the right of detained persons including sentenced prisoners, to have medical treatment and nutrition at state expense guaranteed.[606] The right of prisoners to medical treatment is a major discussion across the world, as limited funding of prisons, congestion in prisons and management flaws of the prison

603 Skype and WhatsApp are popular media applications that allow video calls enabling the parties to see each other via an internet enabled camera device.

604 See the case of *Minister of Justice and Correctional Services and others v Estate Late James Stransham-Ford and Others* (531/2015) [2016] ZASCA 197 (6 December 2016).

605 Constitution RSA s 35(1-5).

606 Constitution RSA s 35(2)(e).

system, have put prisoners at the receiving end of poor health services, exacerbating their already challenged state of being incarcerated.[607]

4.2.19 Section 36: Limitation of rights.

This section points out that the rights in the Constitution RSA may be limited, but the limitations must be "reasonable and justifiable in an open, and democratic society based on human dignity, equality, and freedom…" The Constitution RSA also considers that the nature of the right, importance and extent of the limitation, as well as less restrictive means to achieve the purpose, must be considered before limiting rights. From a patient's rights perspective, this section will be important, as the right to health is not a right entirely protected. The right to human dignity and life are the only rights which are entirely non-derogable. Other rights may be protected to only a certain extent. This section may form the basis of non-justiciability for socio-economic rights and non-performance of some charters or codes which place a demand on the state for positive action.

4.2.20 Section 38: Enforcement of rights.

Patients benefit from this section of the Constitution RSA by approaching a court when there is a rights infringement. A critical part of this section is, however, the categorization of persons who may approach the court. This includes the person whose right has been infringed or threatened, a person acting on their behalf, a class action, and a public interest group or association acting in the members' interests. The advantage this section has in the clamour for the enforcement of patients' rights is that whereas patients may be poor, unable and powerless, the Constitution RSA authorizes the next-of-kin, friends, persons with advanced directives, public interest lawyers or groups and victims of a medical mishap as a class, to demand appropriate relief. This authorization should encourage public interest groups to defend patients whose rights are being violated.

4.2.21 Section 39: Interpretation of bill of rights.

The Interpretation of the Bill of Rights is important, as the Constitution RSA directs that courts, tribunals, or forums must promote democratic principles of

607 See for example *Lee v Minister of Correctional Services* (CCT 20/12) [2012] ZACC 30.

human dignity, equality, and freedom.[608] Significant and germane to this research is the Constitutional provision that in interpreting legislation, the court, tribunal or forum "must consider international law"[609] and "may consider foreign law".[610] The capacity to interpret the phrase, "consider international law", gives life to patients' rights, as there is a plethora of international laws in alignment with the Bill of Rights for patient protection.[611] Other parts of this section emphasize the spirit and intent of the Bill; and the acknowledgement of other such rights by common law, other legislation, and customary law, if they are in consonance with the Bill.[612]

It is obvious that there are very laudable provisions in the Constitution RSA, adequate to guarantee the right of patients to a reasonable extent. However, the rights vested by the Constitution RSA are merely cosmetic without a proper channel for implementation. There is therefore the need to consider if the mechanism for implementation of the guaranteed rights is lax under other healthcare legislation in South Africa, as it is under the Constitution RSA.

4.3 The National Health Act 61 of 2003

Chapter 2 of the SA NHA specifically provides for the rights and duties of healthcare users[613] and personnel. Sections 5 to 20 identify the rights and duties of patients and healthcare subscribers; duties of healthcare personnel; and procedures for laying complaints where there is a breach. Some of the rights protected in this Act include the right of the user to emergency treatment,[614] the right to full knowledge,[615] the right to informed consent,[616] the right to participation in decision making,[617] the right to confidentiality,[618] the right of access to health

608 Constitution RSA s 39(1)(a).
609 Constitution RSA s 39(1)(b).
610 Constitution RSA s 39(1)(c).
611 See the African Charter on Human and Peoples' Rights; see also the World Medical Association Declaration of Lisbon on the rights of the patient.
612 Constitution RSA s 39(3).
613 The terms 'user' and 'patient' are used interchangeably in this chapter because the focus on the healthcare user in this research, is on the healthcare user as a patient.
614 SA NHA s 5.
615 SA NHA s 6.
616 SA NHA s 7.
617 SA NHA s 8.
618 SA NHA s 14.

records[619] and the right to lay a complaint and seek redress on how a patient was treated.[620]

The duties of the user include adhering to the rules of the health establishment, providing accurate information about their health, treating healthcare workers with dignity and respect, and signing a discharge certificate when they refuse recommended treatment.[621] The Act does not only provide for rights of patients but also for the rights of healthcare personnel including their right not to be discriminated against based on their health status, the right not to treat a user who is abusive or sexually harasses him/her (the personnel), and the right to be protected from disease transmission and injury or damage to their person and property;[622] these will be considered *vis-à-vis* possible conflicts they may pose with the rights of a patient.

4.3.1 Emergency treatment

The SA NHA states in section 5 that, "A healthcare provider, health worker or health establishment may not refuse a person emergency medical treatment."[623] This right stems from the ethics of beneficence, one of the ethical pillars of healthcare, which is the duty on health workers to do good to their patients.[624] Patients in South Africa have generally benefitted from this right and would hardly be refused in an emergency; however, there have been a few cases of rejection[625] where the patients have either been refused because they were too dirty to be attended to or too dirty to be put in an ambulance.[626] In 2004, Simon Radebe, a vagrant collapsed in Johannesburg; the emergency service was called and two paramedics propped him against a wall, gave him a cursory look and left

619 SA NHA s 15.
620 SA NHA s 18.
621 SA NHA s 19.
622 SA NHA s 20.
623 SA NHA s 5.
624 Dhai A and McQuoid-Mason DJ *Bioethics, Human Rights and Health Law Principles and Practice* 41.
625 Mahlangu T "Dirty drug addicts refused treatment at city clinics" https://rekordeast.co.za/174016/dirty-drug-addicts-refused-treatment-at-city-clinics/ (Date of use: 25 June 2018).
626 https://rekordeast.co.za/174016/dirty-drug-addicts-refused-treatment-at-city-clinics/(Date of use: 25 June 2018) (Date of use: 25 June 2018); See also Eliseev A "Struck off roll for leaving dirty patient" https://www.iol.co.za/news/south-africa/struck-off-roll-for-leaving-dirty- patient-265283 (Date of use: 25 June 2018).

him at the place where they had placed him. Radebe died about eighteen hours later. A security guard who testified at the Johannesburg Emergency Service Tribunal stated that the paramedics said that they should not have been called for people like Radebe as he was too dirty, and they had better jobs to do. Radebe was a victim of a previous accident and had lived on the street.[627] An Emergency Care Professions Board hearing subsequently removed the names of the two paramedics from the roll, but it was later commuted to a two-year suspension and evidence of further professional training on appeal to the HPCSA, though they were not recalled to their employment.[628]

There have also been cases of the transfer of patients to a government hospital immediately after they achieve minimum stability or a refusal to treat beyond the first response, because of the lack of medical insurance. The patients would be able to sue because they were refused emergency medical treatment, but this law has not been tested sufficiently especially against the private sector's quest to make profit.

The patients' right to emergency medical treatment should be upheld and enforced, and there should be punishment for emergency care workers or doctors who refuse patients outrightly or technically on strictly economic grounds, by transferring them before completing their treatment. The state must devise a means of cushioning the economic effect of emergency medical treatment on private medical outfits by actualizing the national health insurance scheme for all. In so doing, the burden in the conflict between beneficence and upholding the Oath of Hippocrates will not be borne by the medical profession alone and patients' rights will be upheld without any economic or health rationing excuse.

4.3.2 The right to full knowledge

The healthcare provider is duty bound to inform users of their health statuses, range of diagnostic procedures, and treatment options available. They must also be informed of the "benefits, risks, cost and consequences and a right to refusal

627 Ancer J "Medics who left dying vagrant get the axe" https://www.iol.co.za/news/south-africa/medics-who-left-dying-vagrant-get-the-axe-227352 (Date of use: 25 June 2018).

628 Maphumulo S "Disgraced paramedics win appeal" https://www.iol.co.za/news/south-africa/disgraced-paramedics-win-appeal-409760 (Date of use: 25 June 2018).

and implications, risks and obligations of such refusal".[629] As part of this right, the healthcare provider should inform users of all their rights in a language they understand; the healthcare provider should also consider the users' level of literacy.[630]

This right is closely related to the right of a patient to informed consent as it also bestows a duty on the healthcare practitioner to inform the patient and expects that through this information, the user has full knowledge and can make an informed decision about his/her care. This right is a pivotal one by the Act and is in tandem with the constitutional right to self-determination and access to information.

Proof that a patient would have changed his/her decision if (s)he was properly informed of a medical procedure or its effect, can be a cause for an action in medical negligence. A patient may be able to prove that his/her right to have full knowledge was infringed upon if (s)he does not have full knowledge.[631] However, like most medico-legal dilemmas, the idea of full knowledge is illusory and may be unreal, as medical procedures might range from very simple things like being administered a painkiller for a headache to surgery for a heart transplant.

The duty to inform and to ensure that a patient has full knowledge will always be a swinging pendulum based on the patients' knowledge base, education, cultural and natural biases, and other factors.[632] This right, no matter how difficult, must not be disregarded because of its amorphous nature. It must be upheld as one of the paramount rights of a patient. This is because the healthcare profession is built on trust, and healthcare workers are trusted to inform patients to the best of their ability and to the best of a patient's knowledge capacity, such that the patients are well-equipped to make important medical decisions in their lives. The healthcare workers must also respect the patients' autonomy after giving them the necessary information. The right also includes the duty of healthcare

629 SA NHA s 6(1 a-d). See also HPCSA, Booklet 4 Seeking Patient's Informed Consent.
630 SA NHA s 6(2).
631 See *Sibisi NO v Maitin* (311/13) [2014] ZASCA 156 1 October 2014 and *Pandie v Isaacs* [2012] ZAWCHC 47.
632 See *Beukes v Smith* (211/2018) [2019] ZASCA 48.

providers to inform the users of the implications and risks of refusal of treatment.[633]

A noteworthy part of this right is the duty of healthcare providers to inform a user in a language that (s)he understands and to consider the user's level of literacy. This would be easier in community health centres where almost everyone speaks the same language and understands each other, whatever their level of literacy is. The urban centres and cities require the services of interpreters who may need to translate where this right is to be upheld. An investment in language translation technology, which are generally cost intensive would ensure this right is upheld, especially where there is a large influx of foreigners in the community. The HPCSA must encourage the protection of this right as visitors, new settlers, and non-local language speakers may be at the receiving end of potential right infringements.

4.3.3 The consent of the user

The NHA states that a health service will not be provided for a user where the user cannot give consent,[634] except there is a person authorized by the user to give consent on his/her behalf or given such powers by law or by a court order.[635] The user may also be provided with a health service where there is no person mandated to give consent and his/her family members, in a particular order, give consent. The persons eligible, in the order of eligibility are a spouse or a partner, a parent/guardian or grandparent, an adult child or an adult brother or a sister of the user.[636]

It is important to note that where the patient has signified by mandating someone to grant consent on their behalf, it will not be necessary to follow the family order; it is interesting to note the order, which recognizes spouses or partners before siblings; and parents or grandparents before children of the user. The order may not directly affect the rights of the patient, but it is questionable why the law would suggest a partner will be first in line to make a best interest medical decision over

633 See *Castell v De Greef* 1994 (4) SA 408 (C). See also HPCSA, Booklet 4: Seeking patient's informed consent.
634 SA NHA s 7(1).
635 SA SNHA s 7(1a).
636 SA NHA s 7(1b).

the user's child or sister. This research suggests that where there is no specific person appointed or an advanced directive, blood relatives like siblings and children of the patient should be given priority over partners who can change easily.

The Act also prohibits any treatment without the consent of the user, except it is authorized by a court order.[637] This could happen, for example, where non-treatment will be a public health risk,[638] or where it could cause irreversible damage or death to the patient.[639] It also states that the healthcare worker should take reasonable steps to get informed consent, defining informed consent as "consent for health service by a person with capacity and who has full knowledge".[640] Although this section[641] is headed "consent of user", it actually states situations where consent may be done without, within the ambits of the law. Where the patient's right to an advanced directive is obeyed, then his/her autonomous wishes would not have been overridden because (s)he is unable to give consent. Also, the court takes a *parents-patriae* jurisdiction over patients where they are unable to give consent; hence authorization by a court of law or an existing law will cover the healthcare worker and protect the rights of the patient by protecting his/her best interests.[642]

These rights and interests can be infringed upon by a medical decision which is paternalistic. The SA NHA protects patients if they have capacity; but it also considers the public as a factor in the patient's right to consent to treatment. In a situation where the risk to public health is considered higher than the private rights of the citizen, for example, the Ebola Virus, the patient's consent may be overridden and (s)he may be treated according to law.[643]

If a patient may die or suffer irreversible damage when there is a delay in the provision of health service, the patient may be treated without consent. The SA NHA clearly states that this is a situation where the patient has not refused the

637 SA NHA s 7(1c).
638 SA NHA s 7(1d).
639 SA NHA s 7(1e).
640 SA NHA s 7(2,3).
641 SA NHA s 7.
642 *Ex parte Dixie* 1950 (4) SA 784 (W).
643 SA NHA s 7(1d); See also MHCA s 9(1).

health service by conduct, impliedly or expressly.[644] A patient who refuses treatment but is still treated against his/her consent because (s)he may die or suffer damage, may have a cause of action on the basis of infringement against his/her constitutional right to bodily integrity.[645]

The SA NHA in defining the term and identifying who can give informed consent, uses legal terminology like "legal capacity". The phrase "legal capacity" deals with age, mental health and the capacity of the user to make decisions.[646] The SA NHA stipulates procedures within health establishments where a health user is to be admitted without his/her consent to forestall false imprisonment and to uphold the right to freedom of movement or where such a right is to be curtailed, documenting such and justifying it.[647]

4.3.4 The right to confidentiality and protection of health records

The SA NHA protects the confidentiality of health users by stating that, "all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential".[648] The SA NHA also protects the rights of patients by compelling the head of any healthcare establishment to ensure that health records are kept with control measures to keep the medical information without being tampered with. The SA NHA, unlike some other sections without a clear punishment, stipulates a fine or imprisonment not exceeding a year for any person who does not set the measures to protect health records or impairs, changes, alters, copies or modifies health records of patients.[649]

4.3.5 The right of access to health records

The SA NHA compels a person in charge of a health establishment to create and keep medical records of a patient; the patient also has a right to discharge reports where (s)he has used a health establishment.[650] The healthcare provider may

644 *Stoffberg v Elliot* 1923 CPD 148.
645 Constitution RSA s 12(2).
646 SA NHA s 7(3).
647 See MHCA s 9; See also Carstens and Pearmain *Foundational Principles* 900-901.
648 SA NHA s 14(1). See also HPCSA, Booklet 5 : Confidentiality.
649 SA NHA s 17(2).
650 SA NHA s 13. See also HPCSA, Booklet 9: Guidelines on patients' records.

access the records of the user for the user's treatment with his/her consent or for teaching, studying or research with the approval of an ethics committee, save for where the information is used anonymously. The SA NHA does not guarantee the user access to or grant ownership of medical records. It aligns with the common law right of access to medical records, which was outlined in *McInerney v MacDonald,*[651] stating:

> the fiduciary duty to provide access to medical records is ultimately grounded in the nature of the patient's interests in his or her records…information about oneself revealed to a doctor acting in a professional capacity remains, in a fundamental sense, one's own. The doctor's position is one of trust and confidence. The information conveyed is held in a fashion somewhat akin to a trust. While the doctor is the owner of the actual record, the information is to be used by the physician for the benefit of the patient. The confiding of the information to the physician for medical purposes gives rise to an expectation that the patient's interests in and control of the information will continue.[652]

The right of a patient to his/her medical records should be promoted. While this is a contested issue, the writer believes patients should not only have a right of access, but unrestricted access, to their medical records. The healthcare facility should only have sole custody of the records in situations where it is in the patient's best interests or in the public interest. The danger of unrestricted access to health records by patients could be managed by the SA NHA that caters for protection adequately.[653]

4.3.6 The right to lay complaints

The SA NHA provides that "Any person may lay a complaint about the way (s)he was treated at a health establishment and have the complaint investigated."[654] The SA NHA states that complaint procedures must be displayed for all to see; complaints must be acknowledged and addressed or referred. A major challenge in the laying of complaints is the ability of patients to follow laid-down procedures for complaints. Sometimes, the complaint procedures are cumbersome or costly, particularly considering that a user may not be in sufficiently good health or good

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651 *McInerney v MacDonald* 93 DLR (2d) 415, 424, (1992).

652 See Nedwick S (*et al*) "Culture, compassion and clinical neglect: probity in the NHS after Mid Staffordshire" 2015 *J Med Ethics* 229-230.

653 SA NHA s 17 adequately protects the health records of users.

654 SA NHA s 18(1).

financial standing to follow the procedure. Refusal to follow laid-down complaint procedures may be a technical reason to jettison a complaint and this might affect patients' rights. Although the Act states that the procedures must be visible and communicated to users on a regular basis, the law must encourage the procedure to be simple, accessible and affordable.

The SA NHA has shown a lot of limitations, chief of which is the problem of implementation. For example, informed consent may not be possible in cases of complex medical procedures. Many patients tend to either trust the decision of their doctors or make decisions for fear of death. There is also the possibility of a language barrier because not every medical practitioner or patient will understand the native language hence, the probability of a communication gap in some instances. Finally, while having the right to a redress is one issue, pursuing that right is another. The right to lay complaints and pursue a redress in South Africa is an expensive exercise, hence many "abused" patients merely let infringements on their rights go without a reprieve; this limitation seems to be general.

4.4 The Consumer Protection Act 68 of 2008

The Consumer Protection Act 68 of 2008 (hereafter "CPA") defines a consumer as "… a user of those particular goods or a recipient or beneficiary of those particular services…". ''Service'' includes, but is not limited to "any work or undertaking performed by one person for the direct or indirect benefit of another…" and a ''service provider'' is described as a person who, supplies any service.[655] The Act is thus applicable to patients as "consumers" of healthcare services.

According to Slabbert and Pepper,[656] the Act is intended to promote and protect social welfare of consumers and does this by establishing eight fundamental rights for the consumer. The rights are: right to equality in the consumer

655 CPA s 1.

656 Slabbert MN and Pepper MS "The Consumer Protection Act: No-fault liability of healthcare providers" 2011 *SAMJ* 800-801. See also McQuoid-Mason DJ "Hospital exclusion clauses limiting liability for medical malpractice resulting in death or physical or psychological injury: What is the effect of the Consumer Protection Act?" 2012 *SAJBL* 65-68.

market,[657] privacy,[658] choice,[659] disclosure and information,[660] fair and responsible marketing,[661] fair and honest dealing,[662] fair, just and reasonable conditions,[663] fair value, good quality and safety[664] and the right to hold the supplier accountable to consumers.[665] All these are applicable to patients as consumers in healthcare services, either as end users of products purchased by healthcare providers or as direct consumers.

The CPA also states specifically in section 22 that information must be given to consumers (patients) in plain language. Plain language here means in a manner that can be understood by a person with "average literacy skills and minimal experience as a consumer of the relevant goods or services"[666]

The Act also requires that consumers should be made aware of terms and conditions of the service being provided. Section 49, entitled *Notice required for certain terms and conditions* stipulates that the terms and conditions of an agreement should be drawn to the attention of the consumer and if a provision or notice concerns any activity or facility that is subject to any risk "the presence of which the consumer could not reasonably be expected to be aware or notice, or which an ordinarily alert consumer could not reasonably be expected to notice or contemplate in the circumstances; or that could result in serious injury or death, the supplier must specifically draw the fact, nature and potential effect of that risk to the attention of the consumer".[667]

Section 61 of the Act which is categorised under the right to fair value, good quality and safety states that a distributor or retailer of any product is liable for any harm[668] caused wholly or partly by the supply of unsafe goods,[669] product

657 CPA s 8-10.
658 CPA s 11-12.
659 CPA s 13-21.
660 CPA s 22-28.
661 CPA s 29-39.
662 CPA s 40-47.
663 CPA s 48-52.
664 CPA s 53-61.
665 CPA s 62-67.
666 CPA s 22.
667 CPA s 49.
668 CPA s 61.
669 CPA s 61(a).

failures and defects,[670] as well as inadequate warnings or instructions pertaining to hazard arising from use of goods.[671] Pepper and Slabbert[672] exemplify a scenario where a distributor or retailer may be liable, using the example of a pacemaker which fails prematurely to describe the patients need for protection from public harm and exploitation. Prior to the promulgation of the CPA the patient had to prove that the failure was as a result of negligence but now the patient only needs to prove that the pacemaker or any such medical device failed and that (s)he had suffered loss from such failure. In addition, claims do not necessarily have to be from the manufacturer of the defective product and damages may be claimed from anyone in the distribution chain.[673] This is an important provision for the protection of patients as many devices in healthcare settings like blood pressure monitors, HIV test kits, blood sugar level monitors can determine patients' decisions and the malfunction or failure of such may affect the patient negatively. The section protects the patient from harm[674] which may include death,[675] illness,[676] loss or physical damage to property or economic loss.[677] The courts are also empowered to determine whether harm has been caused,[678] the extent and monetary value of such harm[679] and damages as well as determine liability jointly and severally.[680]

4.5 The Mental Healthcare Act 17 of 2002

Persons suffering from mental ill-health and intellectual disabilities have rights as patients. They have rights protected by the Constitution RSA, the SA NHA, as well as the SA Charter. The MHCA protects them specifically. The MHCA brings to the fore the ethical principles in care, treatment, and rehabilitation and makes them law.[681] Some of the constitutional rights which have a strong impact upon

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670 CPA s 61(b).
671 CPA s 61(c).
672 Pepper MS and Slabbert MN "Is South Africa on the verge of a medical malpractice litigation storm?" 2011 *SAJBL* 32.
673 CPA s 61(3).
674 CPA s 61(5).
675 CPA s 61(5)(a).
676 CPA s 61(5)(b).
677 CPA s 61(5) (c-d).
678 CPA s 61(6)(a).
679 CPA s 61(6)(b).
680 CPA s 61(6)(c).
681 Landman AA and Landman WJ *A Practitioner's guide to the Mental Healthcare Act* (Juta Claremont 2004) 25-26.

them include: the right to life, the right to bodily and psychological integrity, the right to freedom and liberty, the right to dignity, the right to freedom of movement and residence, the right to equality, the right to healthcare, food, water and social security and the right of access to courts and just administrative action.

According to Landman and Landman,[682] rights conferred by the MHCA comprise of the right to respect, the right to human dignity and privacy, the right to decide on submission to care, treatment, rehabilitation and admission, the right to proportionate care, treatment and rehabilitation services, the right to have best interests considered, the right not to be exploited and abused, the right to a medical determination of mental health status, the right to intimate adult relationships, the right to representation, the right to discharge reports, the right to decide whether to undergo psychosurgery, the right to treatment other than for mental illness and the right not to be mechanically restrained, the right not to be secluded, and the right not to be unfairly discriminated against.[683]

4.5.1 The right to respect, human dignity and privacy

Although these rights appear in the Constitution RSA, the mentally ill persons require this more than an ordinary healthcare user. The MHCA states clearly that the dignity and privacy of the user must be protected. The users must be provided with health services for improving mental capacity for the development of their full potential and the facilitation of their integration into community life. Care and rehabilitation must be commensurate to mental health status and any intrusion must be for care, treatment, and rehabilitation.[684] The introductory aspect of the third chapter of the MHCA also demands that the decisions taken on the mental healthcare user must be in his or her best interest.[685]

4.5.2 The right to consent

The MHCA provides that a healthcare provider or health establishment should only provide care, treatment, and rehabilitation with the consent of the user;[686]

682 Landman and Landman *A Practitioner's guide to the Mental Healthcare Act* 30-39.
683 Landman and Landman *A practitioner's guide to the Mental Healthcare Act* 31-39.
684 MHCA s 8.
685 MHCA s 7(2).
686 MHCA s 9(1)(a).

this includes the decision to decide to undergo psychosurgery[687] or electro-convulsive treatment. The MHCA provides for exceptions where the user is unable to give consent, which includes treatment based on authorization by a court or review board;[688] where a delay in treatment will be detrimental to the user as to cause him/her or other persons death or permanent damage; or where the delay will cause the user or his/her properties or the properties of others, serious harm.[689]

4.5.3 The right not to be discriminated against

Section 10 of the MHCA protects the right of a user against discrimination on the grounds of his/her mental health status.[690] This provision is crucial because although the Constitution RSA makes provisions against discrimination on several grounds, mental health is not included. The MHCA also states that the care, treatment and rehabilitation received by a mental healthcare user must be comparable to any other healthcare user,[691] with a proviso that policies aimed at promoting the mental health of a person must take cognizance of the mental capacity of the person concerned. In addition, a user's socio-political, economic, religious or cultural background or affinity must not be considered in determining his/her mental status.[692]

4.5.4 The right not to be abused or exploited

The mental healthcare user is to be protected by the healthcare professional or establishment from any form of abuse or exploitation or forced labour.[693] The user is also not to be administered any care or treatment to serve as punishment or for the convenience of other people.[694]

687 Regulation 32(3) MHCA: General Regulations.
688 MHCA s 9(1)(b).
689 MHCA s 9(1)(c).
690 MHCA s 10(1).
691 MHCA s 10(2).
692 MHCA s 12(1).
693 MHCA s 11(a-b).
694 MHCA s 11(c).

4.5.5 The right to confidentiality and access to medical records

The user under the MHCA has a right to confidentiality and the determination of his/her mental health status may only be referred to where it is directly relevant.[695] The user is also owed a duty of confidentiality by the health establishment, except for situations where non-disclosure will prejudice the health of the user or other mental healthcare users. In this circumstance, the head of the national or provincial department or health establishment may disclose information.[696] A user may also be denied his/her right to health records, albeit "temporarily", according to the MHCA, to protect the user and other people.[697] A discharge report shall be issued to a user admitted for care, treatment and rehabilitation.[698]

4.5.6 The right to know their rights

Although this right is popularly subsumed in other laws as part of informed consent, it is noteworthy that it is a distinct right in the MHCA. The MHCA states that users must be informed of their rights before any care or treatment commences.[699] It is suggested that this should be the first right in all legislation protecting patients' rights. The knowledge of rights means that a healthcare user can make decisions and complain (a decision based on valid information) where (s)he believes there has been abuse or a threat of a likely infringement unless a delay could cause death or serious harm.[700]

4.5.7 The right to representation

The Bill of Rights grants access to courts and just administrative action. The MHCA specifically provides for a mental healthcare user, the right to legal representation "when submitting an application, lodging an appeal and appearing before a magistrate, judge or review board..." This right is subject to rights of appearances in court.[701] Another vital aspect of this right is the access by indigent users to legal aid as provided for by the Legal Aid Board. The legal aid provision

695 MHCA s 13(1).
696 MHCA s 13(2).
697 MHCA s 13(3)(a)-(b).
698 MHCA s 16.
699 MHCA s 17.
700 As laid out in MHCA s 9(1)(c).
701 MHCA s 15(1) (a)-(c).

is especially beneficial because a larger percentage of the population is poor and healthcare users, especially in the public system, may require legal aid.

4.5.8 The right of freedom of movement and intimate adult relationships

Although most mental health facilities restrict movement, the user has a right of freedom of movement, but where the commitment is involuntary, (s)he may be restricted partially. Nevertheless, (s)he is entitled to human company and may not be secluded. The regulations allow for seclusion where the user is a danger to him/herself or to others.[702]

Users of the mental health establishments also have a right to intimate adult relationships; although, this right may be limited by the head of a health establishment where the user's capacity to consent is diminished.[703]

The MHCA is a laudable legislation containing noteworthy provisions. However, although it attempts to promote the rights and interests of mental healthcare users, it is uncertain whether this attempt indeed protects the mental health status of the user and the country. The current mental health statistics show that 16.5% of the adult population in South Africa suffer from some form of mental illness, 17% of children and adolescents are sufferers, and 43% of persons living with HIV and AIDs suffer from mental illnesses. These statistics make the need for the enforcement and actualization of the protection of mental health laws a necessity at health facilities. Protection of rights of the mentally ill needs to be a priority if the nation honours everyone's right of access to health.

Having considered national legislation on the protection of the right to health, there is the need to consider supranational legislation – the SA's Charter – that protects patients' rights in South Africa, considering its mode of implementation, as well as its adequacy to cover for the weakness in the administration of national Laws.

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[702] Regulation 1 and 37 MHCA: General Regulations define seclusion and procedure to be taken when seclusion is utilized; however, it is clearly stated that seclusion must not be used as a punishment.

[703] MHCA s 14.

4.6 The Patients' Rights Charter

The SA Charter is soft law which identifies rights of patients in South Africa and their responsibilities. It is part of the guidelines for practice for healthcare professions. It helps to guide professional conduct and is a yardstick for measuring professional misconduct.[704] The introduction to the SA Charter affirms that there has been denial or violation of rights by healthcare services in South Africa,[705] hence the need to launch the SA Charter in a bid to promote, uphold and protect the right to health which aligns with the provisions of the Constitution RSA.[706] The SA Charter proclaims the rights and responsibilities as addressed hereafter.

4.6.1 The right to a healthy and safe environment

The SA Charter asserts that everyone has a right to a healthy and safe environment. This right ensures that patients' mental and physical health is protected by providing adequate water supply, waste disposal and protection from other forms of environmental dangers. The right is strongly connected to the right to health as users of the healthcare service can only be healthy if they have a healthy environment.

It is, however, trite to note that this right cannot always be enforced since some of the factors required to provide a healthy and safe environment are cost-intensive and difficult to ensure. The water scarcity crisis which rocked some cities in South Africa in 2018, showed that although citizens had a right to adequate water,[707] the crisis could not be averted, and no court cases have arisen out of the crisis as at the time of this thesis. In the Gauteng region, there

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704 http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%203%20.pdf(Date of use: 25 June 2018). See also HPCSA, Booklet 3: National Patients' Right Charter.

705 SA Charter s1 http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%203%20.pdf (Date of use: 25 June 2018).

706 The Constitution RSA s 27.

707 Browdie B "Cape Town's water crisis is already posing a risk to public health" https://qz.com/1200949/cape-town-water-crisis-poses-risk-to-public-health/ (Date of use: 25 June 2018).

have also been strikes by environmental sanitation officers, putting the community at risk of an epidemic and other health risks.[708]

4.6.2 The right to participation in healthcare decision making

Participation in decision making is divided into two parts by the SA Charter. Firstly, users of the national health services have a right to participate in the development of health policies. This could either be direct or indirect. They also have a right to participate in decision making concerning their own health.[709]

4.6.3 The right to have access to healthcare

The right to have access to healthcare is given the most attention in the SA Charter as it covers the following sub-headings: timely emergency care, regardless of ability to pay once the facility is open; treatment and rehabilitation with the knowledge of the patient; provision for special needs, which include patients who are children, women, pregnant, disabled persons, and persons living with HIV or AIDS.[710] Allied to this right healthcare is also the "right to counselling without discrimination, violence or coercion on reproductive health, cancer, and HIV/AIDS". A patient, according to the SA Charter, also has a right to palliative care, a right to a positive disposition by healthcare workers following ethical standards of beneficence showing empathy and tolerance. The patient also has a right to health information, in a language he or she understands, which gives him or her knowledge of healthcare facilities and how to use those facilities.

Carstens and Pearmain distinguish between the right to healthcare services and the right to health, emphasizing that the right to healthcare is an accumulation of constitutional rights, which include the right to life,[711] dignity,[712] bodily and psychological integrity,[713] privacy,[714] an environment that is not harmful to

708 https://www.nehawu.org.za/DepartmentOfWaterAndSanitationStrike2018.html (Date of use: 25 June 2018).
709 http://www.doh.gov.za/docs/legislation/patientsright/chartere.html (Date of use: 21 October 2019).
710 SA Charter s 2.
711 Constitution RSA s 11.
712 SA Charter s 10.
713 SA Charter s 12(2).
714 SA Charter s 14.

health,[715] emergency medical treatment, social services, and healthcare services.[716] The authors are of the opinion that the right to access healthcare can only be possible if this collection of rights exists based on the WHO's definition of health that includes physical, mental and social wellness.

4.6.4 The right to knowledge about insurance and medical schemes

A healthcare user has a right to know about their insurance or medical aid scheme, and the user also has a right to challenge decisions of the scheme which concerns him or her. Many users know about their medical aid scheme; but the bone of contention is usually when the scheme makes an adverse decision not to pay for the treatment of one of their members either justifiably or unjustifiably. This has become a major source of concern among patients. Some cases have been decided on this regarding medical cover and the extent to which a medical aid will cover a service rendered, challenging the decision by some medical insurance companies to refuse payment for certain conditions not clearly stated in the health insurance agreement.[717]

4.6.5 The right to choose health services

"Everyone has a right to choose a particular healthcare provider for services or a particular health facility for treatment, provided such choice shall not be contrary to the ethical standards applicable to such healthcare provider or facility".[718] The right to choose healthcare services or to choose a provider is a lofty one and enviable, but this right exists more on record than in practice as there are factors militating against the actualization of the right. This includes cost, location, and access to the facility and medical insurance, among others. The right to choose health services is also not guaranteed, as it is only valid, provided that the patient's choice does not conflict with the ethical policy of the healthcare facility.

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715 SA Charter s 24(a).
716 SA Charter s 27(1)(a and b).
717 *The Council for Medical Schemes v Genesis Medical Scheme* (20518/2014) [2015] ZASCA 161
718 S 2.5. http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%203%20.pdf (Date of use: 25 June 2018).

It is believed that many healthcare users would opt for the best healthcare facilities if they had a real choice. They would prefer not to stand in queues with unending waiting lists. Healthcare rationing in public hospitals and the cost in private hospitals and clinics, make this right a mirage and difficult, if not impossible, to attain. Persons who are also in hard to reach areas which have only one or a few healthcare providers are stuck with those providers as some healthcare facilities are known to service large populations in rural communities where public health is the primary option.

4.6.6 The right to treatment by a named healthcare provider

The SA Charter provides that every patient has a right to know who their provider is and should be attended to by clearly identified healthcare providers.[719] This is a very important right however the circumstances that healthcare users find themselves in, make it difficult to demand conformity with this right. Although it is believed that most healthcare workers will identify themselves on request, the HPCSA and other professional bodies should ensure their members always wear a name tag, with proper identifiable descriptions. This is of greater importance where the patient utilizes a healthcare facility where he/she may be attended to by trainee doctors, nurses or any healthcare worker undertaking medical training.

4.6.7 The right to confidentiality and privacy

The SA Charter provides that confidential information may only be released with the informed consent of the patient, except where the law permits or by an order of the court.[720] The rule of confidentiality is not only provided for by the SA Charter, it is also a constitutional right and protected by the NHA amongst other laws. A patients' right to confidentiality is protected in the Oath of Hippocrates which medical practitioners swear to uphold.[721] Confidentiality is one of the pillars of trust in the healthcare profession as a breach of confidential information is deemed as professional misconduct on the part of the healthcare professional

719 http://www.doh.gov.za/docs/legislation/patientsright/chartere.html (Date of use: 21 October 2019).

720 http://www.doh.gov.za/docs/legislation/patientsright/chartere.html (Date of use: 21 October 2019).

721 https://www.britannica.com/topic/Hippocratic-oath (Date of use: 26 June 2018).

and may be a ground for professional discipline by the regulatory body or by an action in court.

There must be a deliberate attempt at enhanced confidentiality protection for patients in special circumstances or where the divulgence of the information may cause more damage. Persons for whom enhanced protection would be important are persons with sensitive medical information, persons living with HIV or AIDS, persons with mental health issues, persons who are drug dependent and undergoing therapy or persons on alcohol treatment programs.[722]

4.6.8 The right to informed consent

The SA Charter states that, "Everyone has a right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment, and risks associated therewith and the costs involved".[723] This right is promoted across the board in medical law practice, as it is at the centre of patient participation in decision making. The right to informed consent suggests that the patient is not a mere observer but is an active participant in his or her treatment. Informed consent is not a mere mention of the treatment plan but some in-depth discussion about the nature thereof, the treatment options and most importantly, the risks associated. A breach of the right to informed consent will lead to an action in negligence and can be a ground for disciplinary decisions at the HPCSA.

4.6.9 The right to refuse treatment

The SA Charter provides that a patient may refuse treatment either verbally or in writing. This refusal must not be to the detriment of other persons.[724] The right to refuse medical treatment has been tested in courts of law around the world and is one of the major pillars of individual autonomy in medico-legal practice. In *Schloendorff v Society of New York Hospital*,[725] Cardozo J, stated that, "every

722 Tomes Healthcare Privacy & Confidentiality: The Complete Legal Guide 79-80.

723 SA Charter s 2.8. http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%203%20.pdf (Date of use: 26 June 2018).

724 http://www.doh.gov.za/docs/legislation/patientsright/chartere.html (Date of use: 21 October 2019). See also HPCSA, Booklet 7: Guidelines for the withholding and withdrawing of treatment.

725 *Schloendorff v Society of New York Hospital* 105 N.E 92 (N.Y. 1914).

human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. This is true except in cases where the patient is unconscious and where it is necessary to operate before consent can be obtained". The famous dictum of Justice Cardozo has been repeated or reflected in other court decisions and the law has not changed from this perspective. The SA Charter protects patients from being coerced by health professionals into making any decision. The HPCSA decisions in the last decade show intolerance for actions taken by healthcare professionals without the consent of the patient.[726] Although the punishments can be stricter, the firm posture of the association is a pointer to the protection of patients' rights to informed consent.

4.6.10 The right to referral for a second opinion

The SA Charter provides that the patient has a right to a second opinion from a healthcare provider of his/her choice on request.[727] This is a laudable right and a very clear one. It suggests that whilst the patient has a right to choose his or her healthcare provider, his or her choice will not be fixed where (s)he has a reason to change that decision. A patient may become uncomfortable with how he/she is being treated at a health facility and request a change. It is, however, hard to picture the practical actualization of this right considering the technicalities of healthcare, from records to physical transfer, cost and medical aid. But the right exists and must be achievable. Patients must be afforded the option of changing their clinics or hospitals and in public hospitals, where there is another healthcare practitioner with the same qualifications; the patient must be given the opportunity to consult such other practitioner. The reality is that faced with an increased dilemma of healthcare rationing, queues, and waiting lists healthcare, not many patients will ask for a second opinion as this might mean delaying their access to healthcare.

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726 *HSPCA v Ms M Fraser* (PS0107409/211728) [page 11 HSPCA 2018 Judgements] found at https://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/publications/Guilty_Verdicts_December_2018.pdf (Date of use: 26 June 2018).

727 SA Charter s 2.10.

4.6.11 The right to continuity of care

"No one shall be abandoned by a healthcare professional who or a health facility which initially took responsibility for someone's health without appropriate referral or hand-over".[728] The SA Charter protects a patient from abandonment as a health professional cannot forsake a patient having taken initial responsibility for their treatment. A possible scenario is where the practitioner discovers the patient cannot afford the fees or is not covered under the medical aid schemes. A proper hand over is a crucial part of healthcare as it will help the persons who take over care to know the procedures and treatment undertaken prior to transfer. The essence of continuity of care is to protect the best interest of patients and ensure their health is adequately taken care of when they cannot continue at one facility or under the supervision of a specific healthcare professional. The right of access to medical records in the Act also aligns with this act as continued care requires accurate records.

4.6.12 The right to freedom to complain about poor quality of healthcare

The SA Charter guarantees a right to complain about health services.[729] This right is one of the major rights as other rights depend on this right. Where there has been an infringement of the rights of a patient, his right to complain becomes essential. The right not only gives room for complaints but also confers a right to have that complaint investigated and responded to upon investigation.

As with other legislations, the SA Charter contains thoughtful provisions aimed at protecting the rights of patients. It is however evident that the basic limitation is not the laws, but the implementation of same; this had been a recurrent finding. It will appear as though patients' right had bowed to the laws of economics – demand and supply, so much that patients are willing to make compromises for healing. This, coupled with the low number of medical practitioners under the employ of a health establishment in ration to the patients, had to a large extent made some medical practitioners nonchalant about patients' rights. Also, some of the rights vested in the patients are curtailed. For example, although patients

728 SA Charter s 2.11.
729 SA Charter s 2.12.

have the right to choose health services, such right is subject to the ethical policy of the health facility, which can override the right. As a means of solving the demand supply imbalance however, many patients seek medical aid from unorthodox medical practitioners. They are statutorily recognized as the traditional health practitioners and regulated by law. In a bid to fulfil the aims of this research, I will examine next the Traditional Health Practitioners Act 22 of 2007 (hereafter "THPA") and how it protects patients' rights.

4.7 The Traditional Health Practitioners Act 22 of 2007

A very significant part of this research is the existence of some form of protection for patients of traditional healers in South Africa. Many citizens who have been catered for under the Constitution RSA and the HPCSA are clients of the traditional health practitioners. This led to the emergence of the THPA which provides for the establishment of a Council for the management of traditional health practitioners,[730] registration and training of traditional health practitioners,[731] and protection of the interests of members of the public who subscribe to traditional health services.[732] The THPA also provides procedures for discipline and investigations into complaints by users of traditional health services, as well as punishments, including suspension and removal from the register, for wrongdoing.[733]

It is noteworthy that the Act applies to both traditional health practitioners and students engaged in or learning traditional health practice.[734] This is in slight contradistinction with orthodox medicine as the same rules do not usually apply to students of medicine and practicing doctors or nurses. The Act provides that the Council shall among other things, ensure quality of health services within the practice,[735] protect and serve public interest of their users,[736] compile a code of

730 THPA s 2 (a).
731 THPA s 2 (b).
732 THPA s 2 (c).
733 THPA ss (6)(1)(a); 29(1); 34(1) (a-g).
734 THPA s 3(b).
735 THPA s 5(b).
736 THPA s 5(c).

conduct[737] and importantly ensure that traditional health practices comply with universally accepted healthcare norms and values.[738]

This is a major provision and a herculean task for the Council as this will require the cooperation of the traditional health practitioners, standardization of what can be categorized as traditional health practice, adequate engagement to determine what standard practice is, and how to synergize traditional and orthodox health. This is important because traditional health according to the Act is to comply with universal healthcare norms and values.

If the Council is able to achieve its functions and fulfil its mandate inclusively,[739] the Act might become a pacesetter for countries in Africa and across the world, in traditional healthcare management which could improve general health and well-being across the globe and combat the demand-supply conundrum that has plagued effective medical practice in many countries.

On the other hand, medical practice is not only about the protection of the rights of patients, it also includes the definition of the obligation of the patients in a bid to fortify the guarantee of proper healthcare. It is important to note that the South African legislators also took this into consideration and have, by law, prescribed alternate responsibilities for the patients, in view of the rights they enjoy. The same is discussed in the following paragraphs.

4.8 Patient responsibilities and the law

A recent survey on organizational trust and culture in two South African hospitals suggests that although healthcare professionals are aware of their duties under the SA Charter they are appalled by the irresponsibility of patients.[740] It is noteworthy that although the SA Charter was promulgated for the benefit of the patient, it identifies the responsibilities of patients as well. The major difficulty with respect to patients' responsibilities is that there are no effective channels for the

737 THPA s 5(g).
738 THPA s 5(h).
739 The composition of the council is inclusive as most members on the council are traditional health practitioners spread across the provinces, a doctor, a pharmacist, a person with the knowledge of law, community representatives among others. This is essential to ensure some form of professional self-regulation which medicine and other professions usually enjoy.
740 Erasmus *et al* 2017 *IJEH* 10.

monitoring of compliance or discipline of defaulting patients. The circumstances which evoke a referral to patients' responsibilities include cases where patients allege an infringement upon their rights and healthcare professionals justify the infringement or defend themselves by proving that the patients failed to fulfil their responsibilities. Patients' responsibilities outlined in the charter are the responsibility to take care of his or her health, to care and protect the environment, to respect the rights of other patients and healthcare providers, and to utilize the healthcare system properly and not to abuse it.[741]

According to the SA Charter, a patient also has a responsibility to know his/her local health service and what they offer; he or she is to provide healthcare providers with information about his or her health for diagnosis, treatment, rehabilitation or counselling.[742] Some patients have been known to hide information contrary to their responsibility as patients. Where the patient hides information, it is uncertain whether this will be enough defence in a case where a healthcare professional has been sued for negligence. A patient also has a responsibility to inform the healthcare provider of his or her death wishes and other similar decisions at the end of life.[743] The patient has a duty to comply with treatment procedures and to know the cost of the treatment and arrange for payment.[744] The patient, according to the SA Charter, has a duty to protect health records which are in his custody.[745]

The justification for prescribing the responsibility of patients is that the efforts of healthcare providers can be frustrated where a patient refuse to fulfil these responsibilities. Where this is the case and the health of the patient takes a negative turn, the medical practitioner who had ethically cared for the patient is exculpated. If the medical practitioner had been negligent and the patient irresponsible, the defence of contributory negligence will suffice where the downturn in the health of the patient can also be attributed to his or her irresponsibility.

741 SA Charter s 3.
742 SA Charter s 3.5, 3.6.
743 SA Charter s 3.7.
744 SA Charter s 3.8,3.9.
745 SA Charter s 3.10.

In a bid to test the effectiveness of the implementation of these legal provisions, some selected cases on patients' rights are examined following.

4.9 Selected cases on patients' rights in South Africa

A few cases will be highlighted to assess patient's rights in South Africa. Although these cases cannot cover the entire extent of patients' rights infringement and enforcement, they mirror the society and the recourse to law where there has been some infringement of the rights of patients.

4.9.1 Soobramoney v Minister of Health (KwaZulu-Natal) 1998 1 ALLSA 266 (CC)

The case of Soobramoney is a *locus classicus* on patients' rights and access to treatment in South Africa. It is one of the few cases where the Constitution has been put to the test and an interpretation was required on the right to emergency medical treatment and the right to life. The case concerned an unemployed diabetic man who also suffered from ischaemic heart disease and cerebro-vascular disease which led to a stroke in 1996. He was suffering from incurable and irreversible chronic renal failure. Treatment in his case was dialysis, which would have kept him alive longer. The state hospital refused to accede to his treatment demands based on a lack of resources. The court held that the refusal of the hospital was not on an infringement on Mr Soobramoney's right to life or his right to emergency medical treatment. The court held that the hospital could not be compelled to treat all patients based on diverse and compelling medical demands and his inability to meet the hospital's criteria. His right as a patient was to be upheld within the context of available health services to all. The hospital was, however, unable to accede to his treatment demands because they did not have the necessary resources/equipment for his treatment, not because they did not want to treat him. The government is expected to show good faith and show that it had acted rationally before making the decision with regards to health rationing.[746] The hospital was shown to have done so.

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[746] The court's decision in *Soobramoney* was based on the idea of progressive realization of the right to have access to health services, subject to available resources. This has been criticized by scholars as the right to life is deemed restrictively interpreted by the court in

4.9.2 The Life Esidimeni case

Although mental health has been discussed in a section of this research and some cases stand out, either in the protection or abuse of patients' rights, the Life Esidimeni case is noteworthy. It is believed that this case has had one of the highest casualties relating to patients' rights in South Africa in the last decade. The MHCA, the Constitution RSA, and the SA NHA prohibits discrimination against those with mental illness and other disabilities. These laws recommend the promotion of patients' right to privacy and human dignity; however, this case showed no such respect for the rights of the patients involved in the case, as revealed by the Ombudsman report and the arbitration hearing of the case.

In 2015, the Gauteng Department of Health terminated a contract for the care of mentally ill persons with a private practitioner, Life Esidimeni hospital, which had delivered health services to mentally ill patients for over five decades to cut costs and save money. The patients were transferred to health facilities run by Non-Governmental Organizations (hereafter "NGOs") in conditions that were inhuman and inappropriate.[747] Some of the NGOs were ill-prepared, were in far-off locations and did not receive subsidies from the government. As a result of this infringement and gross mismanagement the patients were starved and not cared for. Tragically about 94 of these patients died between 23 March 2016 and 19 December 2016.[748] These deceased patients had been handed over to 27 NGOs for treatment. As at the time of the Ombud's report, the NGO's licenses were found to be invalid.

The officials in charge of the process had taken poorly planned steps to transfer the care of the patients to these NGOs. They had gone so far as to mislead the

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this case. See Pieterse *Can Rights Cure* 64; also, Pieterse M "A different shade of red: socio-economic dimensions of the rights to life in South Africa" 1999 *SAJHR* 381-383.

747 Dhai 2017 *SAJBL* 2,3. See also McQuoid-Mason DJ "Life Esidimeni deaths: can the former MEC for health and public officials escape liability for the deaths of the mental patients on the basis of obedience to 'superior orders' or because the officials under them were negligent" 2018 *SAJBL* 5-7. Ferlito B and Dhai A "The Life Esidemeni tragedy: Some ethical transgressions" 2018 *SAMJ* 157; Dhai "The Life Esidimeni tragedy; Moral pathology and an ethical crises" 2018 *SAMJ* 382-385.

748 Makgoba "The Report into the Circumstances Surrounding the Deaths of Mentally Ill Patients: Gauteng Province" Office of the Health Ombud. See also Moseneke D The Life Esidimeni Arbitration report http://www.saflii.org/images/LifeEsidimeniArbitrationAward.pdf (Date of use: 11 June 2018).

court to prevent the court from stopping the transfer of these patients. Families of patients said some were not clothed, others had been given the same sets of medication daily and they mainly died of hypothermia or dehydration. The report revealed that the human rights of these patients were violated. In March 2018, the arbitral award was given in favour of the families of the deceased for the cost of the funeral and as compensation for the trauma of their loss.[749]

This case illustrates the importance of protecting patients' rights. Many unfortunate events which have taken centre stage in world news did not have up to a hundred casualties, however over 94 patients who lost their lives, and their dignity, in such a tragic manner generated only minimal outrage globally.

4.9.3 Hoffman v South African Airways 2001 (1) SA 1 (CC)

This case dealt with right not to be discriminated against, and although Mr. Hoffman was not a patient, he was a person living with HIV. The airline, South African Airways, had a practice of not employing people living with HIV as cabin attendants. The airline defended the policy claiming the intent of the policy was the wider protection of the airline passengers. The claim included the assertions that people living with HIV may react negatively to the yellow fever vaccination, might contract and transmit other diseases to passengers, and may turn out to be a bad training investment based on their life expectancy.

Although the airline made a seeming case, the court held that this practice was unjustified. In a unanimous decision delivered by Justice Ngcobo, the court held that Mr. Hoffman had a right not to be unfairly discriminated against based on his medical status. The assertions of the airline were baseless as it concerned Mr. Hoffman as his HIV had not advanced to the immunosuppressive stage, and hence did not pose a risk to passengers as suggested by the airline. A claim that this was the general practice by airlines did not suffice. This is of significance as a medical negligence claim could have been defended if the healthcare practitioner was able to use the *Bolam* test[750] appropriately, claiming this was

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749 Masweneng K "Government must pay R1.2million to life Esidimeni families" https://www.timeslive.co.za/news/south-africa/2018-03-19-government-must-pay-r12m-to-life-esidimeni-families/ (Date of Use: 10 July 2019).

750 *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 (QB) at 122B-C): A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as

reasonable standard medical practice, although the *Bolitho*[751] gloss would make an obstinate action unjustified- even if all healthcare practitioners saw it as standard practice.

The Constitutional Court stated that commercial requirements should not prejudice and there must be respect for human dignity, compassion, and understanding, considering that persons living with HIV are already stigmatized and therefore deserve protection. The Constitutional Court, aligned with the Court of Appeal's decision setting aside the decision at the High Court which had agreed with the airline's passenger/risk protection theory, ordered the airline to make an employment offer to Mr. Hoffman, deeming it unfair to ask that the employment be pre-dated to when he applied.

4.9.4 Jansen van Vuuren and Another v Kruger 1993 (4) SA 842 (SAA)

This case was on the right of a patient to confidentiality. In this case, the plaintiff alleged that his right to privacy was dishonoured when his medical practitioner disclosed his HIV positive status to another medical practitioner, although in a private capacity. The court held that the doctor-patient relationship requires that the patient's right to confidentiality should be upheld considering that stress caused by the illegal disclosure could have hastened the onset of AIDS in the patient. Mr. McGeary had lived in a homosexual relationship with Van Vuuren in Brakpan, South Africa. They were well-known residents of the town and their relationship was inferable. They then moved to another town, Nylstroom, starting a business venture, while retaining some connection with Brakpan, the city in which they had resided prior to Nylstroom. The plaintiff applied for life insurance from the Liberty Life Insurance Company. As part of the requirements for the insurance, the company required a medical report stating the HIV status of the plaintiff. The plaintiff chose to ask the first defendant who had been his

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proper by a responsible body of medical men skilled in that particular art… a doctor is not negligent, if he is acting in accordance with such a practice, merely because there is a body of opinion that takes a contrary view. At the same time, that does not mean that a medical man can obstinately carry on with some old technique if it has been proved to be contrary to what is currently accepted as informed medical opinion.

751 *Bolitho v City and Hackney Health Authority*[1997] UKHL, 46 at 778d-g: the court is not bound to hold that a defendant doctor escapes liability for negligent treatment or diagnosis just because he leads evidence from several medical experts who are genuinely of opinion that the defendant's treatment or diagnosis accorded with sound medical practice.

practitioner for about ten years, to prepare his medical report. A blood sample was taken at the second defendant's laboratory for testing, to establish whether he was infected with the virus. The test showed that the plaintiff was HIV positive and the second defendant informed the first defendant of the results from the laboratory. The first defendant, who had been the plaintiff's doctor, arranged an appointment to discuss the results of his test with him. The plaintiff was distraught with the results and expressed his desire to have the information remain confidential, which his doctor assured him of. The first defendant informed another medical practitioner, Dr Van Heerden, and a dentist, Dr Vos, of the plaintiff's HIV status over a game of golf. Dr Vos was the plaintiff's dentist at some time in the past. Dr Van Heerden's wife was, however, in business with the plaintiff, Mr. Van Vuuren. His ex-wife and former-in-laws were also in communication and in a friendly relationship with Mr. Van Vuuren. Dr Vuuren informed his wife, and though there was no evidence that Dr Vos informed his wife, it was assumed that he did. The news about the plaintiff's HIV status spread in the community and he instituted proceedings against the two defendants, claiming a breach of confidentiality, affecting his right to privacy and his right of personality.

The Supreme Court of South Africa (Appellate Division), held that the first defendant breached his professional confidence by disclosing the result of the test, and that the plaintiff had been injured in his rights of personality and his right of privacy. The court further held that the duty of confidentiality is both an ethical and a legal duty. The court therefore found that the first defendant had abused his professional relationship. The court awarded an aggravated award of R500 000 and cost of litigation against the first defendant.

4.9.5 TAC and others v Minister of Health and others 2002 (5) SA 721 (CC)

This case was launched by the Treatment Action Campaign (hereafter "TAC"). It contended that the government was under obligation to make nevirapine available in public health facilities to pregnant women with HIV and to mothers and their new-born babies for the prevention of mother-to-child transmission. The demands of the TAC also included a government national plan on voluntary counselling and testing as well as a substitute for breastfeeding for mothers with

HIV. This right hinged on their constitutional right to health. The Department of Health appealed the court's decision which directed the department to provide counselling support, and nevirapine. The appeal was launched because no time limit was given by the court to provide the drug to mothers with HIV and the court did not consider the budgetary constraints of the department and the infrastructure required for the counselling of patients. The Appellate court held that implantation of the interim execution order would not result in irreversible harm to the Government. The court further held that the government had failed to show why it should not commence the implementation of the order of the High Court and therefore refused application for leave to apply.

Whereas this chapter discusses the rights of patients in South Africa in general, a particular medical condition stands out in South Africa as the most challenging health matter in modern times, this is HIV and AIDS. This classification of patients' rights led to the institutionalization of further measures to protect patients with this medical condition, not as a form of discrimination, but in a bid to guarantee their enjoyment of their fundamental human rights. Measures, therefore, to guarantee the protection of the rights of patients living with HIV and AIDS are considered in the following paragraphs.

4.10 HIV and AIDS a peculiar case for patient's rights protection

HIV[752] is a virus that attacks and damages the body's immune system rendering it incapable of fighting infections. A person with HIV is also susceptible to contract develop a disease called AIDS[753] The HPCSA guideline preamble describes HIV and AIDS as the most challenging health matter of modern times. In addition, it creates medical, legal, ethical, social, political and fiscal issues.[754]Persons living with HIV and/or AIDS require special protection under the law as they are not just

752 Human Immuno-Deficiency Virus, A retrovirus which causes AIDS https://en.oxforddictionaries.com/definition/hiv (Date of use: 28 June 2018).

753 Acquired Immune Deficiency Syndrome https://en.oxforddictionaries.com/definition/aids (Date of use: 28 June 2018). See also Barret-Grant K (*et al) HIV/AIDS and the law: a resource manual* 3rd ed (AIDS Law Project and the AIDS Legal Network Johannesburg 2003) 10.

754 http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/ethical_rules/Booklet%206%20Gen .pdf (Date of use: 28 June 2018).

patients; they are patients who deserve protection considering the peculiarity of the epidemic and the legal attention it has attracted.

The slightly variable margin statistics from the UNAIDS[755] shows that South Africa has the largest HIV epidemic in the world with nineteen percent of the global number of people living with HIV, fifteen percent of new infections and eleven percent of AIDS-related deaths. In the year 2016, South Africa had two hundred and seventy thousand new HIV infections, one hundred and ten thousand AIDS-related deaths, and seven million, one hundred thousand people living with HIV – considering the fact that these are for reported cases. It is also important to note that fifty-six percent of those living with HIV accessed anti-retroviral therapy, ninety- five percent of pregnant women living with HIV accessed prophylaxis to prevent mother to child transmission, and twelve thousand children were newly infected with HIV via mother to child transmission.[756]

Issues pertaining to patients' rights are particularly relevant in South Africa. This is because patients complain about involuntary testing for HIV; persons living with HIV complain also about the abuse of their right to confidentiality and consent to treatment; especially where the healthcare personnel are aware that they are living with HIV.[757]

The HPCSA guidelines give clear stipulations when patients' HIV status can be revealed and the courts frown on any form of discrimination against persons living with HIV as seen in the *Van Vuuren* case.[758] The rights of persons living with HIV must be protected to maintain public trust in the profession. Persons living with HIV/AIDS are entitled to support treatment, and a confidentiality status that must be maintained, save for overriding public interest. The fact that in the *Van Vuuren* case the disclosure was to another health professional, although in non-professional circumstances, was not justified. However, same may be justified after having considered, explained and accepted responsibility for the decision, and where the healthcare worker considers disclosure to another healthcare

755 Joint UN Programme on HIV and AIDS.
757 Barret-Grant *et al HIV/AIDS and the law* 118.
757 Barret-Grant *et al HIV/AIDS and the law* 118.
758 *Jansen van Vuuren and Another v Kruger* 1993 (4) SA 842 (SAA).

professional to be in the best interest of the patient or in supervening public interest. The standard practice is that a person living with HIV is counselled as to the advantages of informing other health workers treating him or her and in other cases, persons who might be infected, with the expectation that the person living with HIV will either inform them or protect them from any danger but will still be shielded from stigma or discrimination by his or her health workers.

The law has taken a stern stand to supplant discrimination based on the health status of South Africans and would punish medical practitioners who infringe on this right. This is because, although they are patients, persons living with HIV/AIDS are first humans and therefore enjoy dual protection of their human and patients' rights.

4.11 Enforcing patients' rights in South Africa

The enforcement of patients' rights in South Africa is a huge task. The gap which clearly exists between the rich and the poor, as well as the political coloration that the history of apartheid embeds into the system, means that there are deep-seated challenges which must be overcome before the actualization of rights can take place. Healthcare professionals are under obligation and have a duty to the citizenry; to ensure they have equal enjoyment of the rights provided by law. A greater responsibility rests on the professional ethical bodies to continually moderate the activities of health personnel and ensure that they maintain the standards of their respective professions and abide by the guidelines to the best of their capacity. Stiffer penalties for erring healthcare personnel could be implemented. The role of the Ombudsman in protecting the rights of patients cannot be overemphasized but will be considered in detail in the comparative chapter.

The training and revalidation of healthcare personnel will address the rights of patients in the following ways: participation in decision making, access to healthcare, being treated by a named healthcare provider, ensuring informed consent, the right to refusal of treatment, the right to a second opinion, and continuity of care. The courts of law also have a duty to prioritize the protection of patients' rights. Technicalities and legal procedure must not limit the courts in

promoting the rights of the patient and wielding the axe where the erring healthcare personnel are recalcitrant. Judgments of court must also emphasize and underscore the importance of rights of a patient in South Africa, so that both the patient and the healthcare personnel and establishment can rest assured that the law is on their side, not just to the letter but also in practice.

The establishment of special courts or tribunals to settle medico-legal disputes will also speed up the judicial process. The National Health Insurance Scheme when fully functional has the potential to become a source of protection for the rights of patients in South Africa. It is, however, uncertain whether the scheme will be managed well enough to achieve its projected objectives. A major challenge of the healthcare system in South Africa is a lack of or insufficient resources, a fact which has been queried by some scholars.[759] It is believed that when most citizens are covered by the scheme, there will be an eradication or reduction in refusal of patients for emergency treatment, and there will be reasonable access to healthcare.

4.12 Conclusion

The Constitution RSA, the SA Charter, other legislations and case law reviewed above, are evidence of an attempt by the government and professional regulators to protect the rights of patients. I have underscored in this chapter various innovative adoptions to secure patients' rights, including the regulation of traditional medicine. I have, however, come to an unavoidable conclusion that the rights do exist, but the realization of the rights, the enforcement, protection and remedying of infringements are major challenges in the society. This is becoming the major limitation in the protection of patient's rights in Africa. This is further underlined by the social, institutional and cultural ills that have been woven into the fabric of the nation's existence. The patient is already in a disadvantaged state. This societal ill further mounts on the patient, the need for additional support to be able to demand his/her rights.

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759 *Government of the Republic of South Africa and others v Grootboom* 2001 (1) SA 46 (CC), see also Carstens and Pearmain *Foundational Principles* 45.

The realization of patients' rights in South Africa is achievable, but it is a herculean task. The nation must conquer the demons of poverty and violence to achieve the right of access to healthcare, food, water, and social security, a right from which all other rights of patients can be derived. The government, which is usually blamed and rightly so, must take the duty of actualization of the Constitution, the SA NHA, the SA Charter, and every other patients' right legislation seriously. The law is not weak on its own; however, there is a need for all hands to be on deck for the law to have a life and for lawbreakers to pay the price. In addition, government agencies, legal aid councils and professional self-regulatory bodies have a responsibility to patients to achieve a patients' rights conscious South Africa.

Lack of implementation has been a recurring ill in the two jurisdictions considered in chapters three and four and this researcher is forced to ask - "is this the status quo?" "is this problem of implementation universal or are there nations with functioning patients' rights protection mechanisms?". If the ill is not general, what then are the underlining cause of the legislative dirge in the protection of rights of patients in Nigeria and South Africa? In a bid to attempt to resolve all these posers, I consider next the protection of patients' rights in the UK, the third jurisdiction for study, then attempt a comparative analysis of the protection of patients' rights in all three jurisdictions. An examination of the patients' right in the UK will therefore be the focus of the next chapter of this research.

CHAPTER 5: PATIENTS' RIGHTS IN THE UNITED KINGDOM: THE NHS APPROACH

5.1 Introduction

In the previous chapter, I examined patients' rights in South Africa. I examined the statutory protection of patients' rights under the Constitution RSA, the SA NHA, the MHCA, the CPA, the THPA, the SA Charter and other extant laws. There seems to be a common problem between the protection of patients' rights in Nigeria and South Africa, which is the issue of implementation of the laws. This is because both jurisdictions have adequate legislation to curb the infringement of patient's rights substantially. Innovative legislation in South Africa, the THPA that regulates traditional health healers and their apprentices has been pointed out as well as the protection of the rights of persons living with HIV and AIDS.

The aim of this chapter is to consider the protection of patients' rights in the UK in a bid to determine whether all these jurisdictions share a common weakness in the implementation of the legislative protection of patients' rights, and whether there are innovations in the UK which they can emulate.

The NHS Constitution is the primary focus. The historical background is briefly considered as well as what is currently obtainable under the NHS. This analysis will help to elucidate which practice is better in the UK as well, the legal framework for the protection of patients' rights prior to or after the application of the NHS Constitution. Case law is also analysed to test the protection of patients' rights in the UK. Attention is also given to the indemnity of patients where the NHS seeks to settle obvious cases of negligence out of court, although with the approval of court on settlement; this is to show that patients' rights protection in the UK has gone beyond courtroom advocacy alone. The Care Quality Commission (hereafter "CQC") and their effect on the protection of patients' rights in the UK, as well as other institutional protection of patients' rights are also scrutinised. Finally, the option of the pursuit of medical care in private health facilities and how this affects the enforcement of patients' rights in the UK is touched on.

5.2 A background to patients' rights in the UK

> We pay €18 per family per week for our National Health Service. The fact that we pay most of this money in taxes rather than in payment for treatment does not make the cost any less real. Yet, too many of us behave as if we are being given charity - there is a tendency towards passive acceptance of health services. This is not the way for patients to get the highest quality of service.[760]

The statement above is credited to Michael Shanks, who was Chair of the National Consumer Council (hereafter "NCC") in the UK in the year 1983. He stated this in his foreword to the "Patients' Rights Guide" which he referred to as the first booklet to provide information about services available to patients, their rights and responsibilities, in addition to how they can influence decision making in health services.[761] He stressed that the NHS is not free; after all, it is paid for in taxes. He also emphasized that patients will only get the best from the NHS if they know what they should reasonably expect. The Patients' Rights Guide[762] from which the quotation above was lifted, became a pivotal point for patients' rights in the UK in earlier times. It defined patients' rights widely in relation to a:

> … doctor's responsibility under the Common Law and under their contract and ethical code. It covers those rights which patients can reasonably expect to arise from their doctor's professional duties.[763]

The Patients' Rights Guide was explicit and detailed. It explained how to become a patient; who a patient is; the elements and issues of consent to medical treatment; managing information; childcare in health services; complaint procedures as well as procedures for seeking redress.[764] Unfortunately, decades after this first document which was drafted to specifically enhance the understanding, cooperation and trust between doctors and patients,[765] the rights of patients are still being abused.

The UK comprises of England, Wales, Scotland and Northern Ireland. Each country in the UK operates independently of the other and all are accountable to

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760 *National Consumer Council Patients' Rights Guide* 3.
761 NCC *Patients' Rights* 3.
762 NCC *Patients' Rights* 3.
763 NCC *Patients' Rights 3.*
764 NCC *Patients' Rights* 4.
765 NCC *Patients' Rights* 4.

their governments. The NHS England was further established as a Commissioning Board on 1 October 2012, is publicly funded and provides (mostly free) services to all legal residents of the UK.[766] The NHS is based on three core values, namely universality, comprehensiveness, and free medical care at the point of delivery. [767]

The vision of the NHS was to address the health inequalities in England, which had been caused by the unequal distribution of income, power and wealth. The policies and processes of the NHS were designed to ensure the elimination of discrimination, harassment, and victimization. The planning and commissioning of healthcare services at grassroots is done by the Clinical Commissioning Groups (hereafter "CCGs").

The CCGs are clinically led statutory bodies created in terms of the Health and Social Care Act, 2012 (hereafter "HSC Act").[768] Commissioning of health services requires an assessment of the local healthcare requirements and securing those services from health practitioners to meet the needs. The impact of the CCGs is evaluated in the community. This obligation imposed on the CCGs and the NHS Board translate to an enablement of the enjoyment of the right to healthcare by every patient in England. Where a patient is deprived of or denied healthcare, an officer or office will be directly held responsible, because the HSC Act has imposed a duty on members to ensure that the populace is granted access to healthcare with no discrimination.[769] The advantage of this is that patients will immediately know who to hold responsible for a denial of service. In addition, the inclusion of patient representatives and community representatives in the CCGs aligns with the NHS' goal of patient-centred care. It is unfortunate that it seems these principles are no longer upheld, as the NHS changed with the times.[770] For

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766 Legal residents are citizens or persons with permanent residence status in the UK.

767 NHS England "Guidance for NHS commissioners on equality and health inequalities legal duties" https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf (Date of use: 2 February 2019).

768 https://www.nhscc.org/ccgs/ (Date of use: 2 February 2019).

769 Haggett E *the Human Rights Act 1998 and access to NHS treatments and services: A practical guide* (The Constitution Unit London 2001) 14.

770 Talbot-Smith A and Pollock AM *the New NHS: A guide to its funding, organization and accountability* 1st ed (Routledge London 2006) 2.

example, overseas visitors[771] now need to pay a surcharge to access services, which are free for legal residents.

The rights of patients under the NHS are spelt out comprehensively in the NHS Constitution.[772] Prior to the NHS Constitution, there was an NHS Patients' Charter with provisions similar to the current Constitution.[773] The Charter was first considered in 1991, and updated in 1995 to reduce waiting periods for operations (which sometimes lasted for two years), to reduce outpatients waiting at hospitals and to give more general information to patients.[774] The Charter focused on protecting a patient's right of access to health services and his/her right to personal consideration, respect, and information. It also highlighted procedures for registration with a general practitioner (hereafter "GP"). Once registered, a patient had a right to regular health check-ups. The process was also explained if there was a need to change a registration with a GP. Patients had a right to be prescribed appropriate drugs and medicines. Pensioners, children under sixteen years of age, pregnant women, nursing mothers and students studying full time also had a right to free drugs and medicines.

The Charter provided for rights and expectations by the addition of three important rights, namely:

> a right to detailed information about local health services including quality standards and maximum waiting times; a right to guaranteed admission for treatment by a specific date no later than two years from when placed on a waiting list by the consultant and a right to have any complaint about NHS services investigated with a full and prompt reply by the Chief Executive or General Manager.[775]

The Charter defined "rights" as "that which all patients will receive all the time" and "expectations" as "the standards of service which the NHS is aiming to

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771 Non-residents with stay of six months or more in the UK.

772 Department of health and social care "Guidance: the NHS Constitution for England" https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england (Date of use: 21 June 2019).

773 NHS *The Patient's Charter & you*.

774 NHS *The Patient's Charter & you* 2.

775 Burke A, Ellis N and Griffith B "The patient's view" in Tschudin V (ed) *Patient's Charter (Ethics)* (Scutari Press London 1995) 106.

achieve."[776] It is also an expectation that "the NHS will respect privacy, dignity, and religious and cultural beliefs at all times and in all places".[777]

The Charter was replaced by the NHS Constitution which became the chief legislation on the protection of patients' rights in the UK, hence its importance.

5.3 The NHS Constitution and patients' rights

The NHS Constitution is guided by seven key principles. These principles are: (1) the provision of a comprehensive service available to all; (2) ensuring access to NHS services based on clinical need and not on the ability of the patient to pay; (3) aspiring to the global best practice standards; (4) having the patient at the heart of all the NHS does; (5) working across organizational boundaries; (6) commitment to providing the best value for its public funding, and; (7) accountability to the community, patients and the public it serves. Based on these guiding principles, the NHS Constitution provides for certain rights for patients in the UK, as discussed in the following paragraphs.

5.3.1 The right to access health services

Access to local health services – like general practitioners, hospitals, clinics or health improvement centres. Local authorities may charge for some services but not for those required by an individual for the improvement of his/her life. Although the phrase, "free" is bandied around for most services, there are now payments for a number of services, making many services which are expected to be or deemed free, no longer free. The exceptions include dental appointments, some prescription charges and treatment for overseas visitors; the latter has always been paid for and is not on the presumed free treatment list which varies per time.[778]

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776 NHS *The Patient's Charter & you* 4.
777 NHS *The Patient's Charter & you* 4.
778 Local Authorities Public Health Functions and Entry to Premises by Local Healthwatch Representatives Regulations 2013 regulation 9 http://www.legislation.gov.uk/uksi/2013/351/regulation/9/made (Date of use: 6 February 2019).

The list below explains the circumstances under which any person may access the NHS related services free of charge; it applies to all patients, except those who travelled to the UK specifically for any of the listed treatments.[779]

- Treatment given in an emergency by the accident and emergency unit, but not extending to treatment upon admission thereafter.
- Family planning services, excluding termination of pregnancy and fertility treatments.
- Treatment for some infectious diseases.
- Psychiatric or other illnesses caused by:
    i. torture
    ii. female genital mutilation
    iii. domestic violence
    iv. sexual violence.

Eligibility for free treatments for other conditions not listed above is determined by residency or exemption status in the UK. Ordinary residents[780] or exempted persons[781] are not required to pay anything for healthcare services. Nationality, tax compliance or a national insurance contribution are not considered as a measure for access if a patient is an ordinary resident.[782] However, this provision does not apply to non-residents and once the service provider has ascertained that a person is required to pay, the person will be required to pay in full before treatment is given, except if it is an emergency.[783] Where the person is unable to

779 Department of Health "Guidance on implementing the overseas visitor hospital charging regulations" 10 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474278/Implementing_overseas_charging_regulations_2015.pdf (Date of use: 15 June 2019).

780 https://legaldictionary.thefreedictionary.com/ordinarily+resident (Date of use: 15 June 2019).

781 Department of Health "Guidance on implementing the overseas visitor hospital charging regulations" 11 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474278/Implementing_overseas_charging_regulations_2015.pdf (Date of use: 15 June 2019).

782 Department of Health "Guidance on implementing the overseas visitor hospital charging regulations" 39 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474278/Implementing_overseas_charging_regulations_2015.pdf (Date of use: 15 June 2019).

783 The National Health Service (Charges to Overseas Visitors) Regulations 2011 determines the fees to be paid by persons not ordinarily residents.

pay, the patient will be required to submit an "undertaking to pay".[784] Failure to pay, while using a temporary visa, may result in non-renewal of the visa.[785]

The NHS regulations of 2011 and subsequent regulations are a moderation of the NHS policies of free and comprehensive healthcare. These regulations can also be interpreted as a direct response of the government to its inability to manage the health system and protect patients' rights. The regulations which restrict cover for health services, may become a source of discrimination for travelling patients. There is insufficient data as to the effect these regulations have had on the health services to immigrants, but it may be discriminatory because the confirmation of immigration status becomes a requirement before the NHS will provide healthcare for free to foreigners.[786]

The perceived privatization of the NHS is seen as a direct affront on the primary right of patients in the UK to free healthcare. This trend is believed to have been initiated up to four decades ago, with the underfunding of the NHS and the radical reshaping of it by the Thatcher-administration which led to an end of comprehensiveness and the acclaimed financial strangulation of the NHS.[787] The current health system in the UK is a mixed economy of healthcare by allowing public-private partnerships, especially with the emergence of myriad private diagnostic and treatment centres, making the state an enabler or regulator, but not always the provider.[788] Notwithstanding the trend, expanded access to care and the availability of insurance benefits might improve healthcare delivery.[789] It is important to note that in the UK, patients may not be refused NHS services on

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784 Department of Health "Guidance on implementing the overseas visitor hospital charging regulations" 117 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474278/Implementing_overseas_charging_regulations_2015.pdf (Date of use: 15 June 2019).

785 https://www.hr.admin.cam.ac.uk/hr-services/relocating-uk/living-uk/healthcare/eligibility-nhs-treatment (Date of use: 15 June 2019).

786 Department of Health "Guidance on implementing the overseas visitor hospital charging regulations" 117 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/474278/Implementing_overseas_charging_regulations_2015.pdf (Date of use: 15 June 2019).

790 NHS Act 2009 section 3 http://www.legislation.gov.uk/ukpga/2006/41/contents (Date of use: 6 February 2019).

790 NHS Act 2009 section 3 http://www.legislation.gov.uk/ukpga/2006/41/contents (Date of use: 6 February 2019).

790 NHS Act 2009 section 3 http://www.legislation.gov.uk/ukpga/2006/41/contents (Date of use: 6 February 2019).

unreasonable grounds. Patients may not be denied healthcare on the grounds of age, disability, race, gender or gender reassignment, sexual orientation, pregnancy and maternity, religion or belief, or marital or civil partnership status. These are considered unreasonable grounds.[790] Reasonable grounds to refuse to treat a patient may include those cited by the Royal College of Nursing,[791] namely:

- where the physician fears violence;
- in cases of racial or sexual harassment of the service provider by a patient;
- in cases of non-availability of appropriate equipment;
- where the required treatment is outside the scope of the attending physician, in which case the patient should be referred to a competent physician;
- where there is conscientious objection[792] in which case suitable personnel should take over the patient;
- where the patient is a relative or friend of the physician; and
- where the health personnel are required to do something illegitimate or unlawful.

Grounds of refusal must be documented, and the documentation, kept properly for proof, should the patient opt to sue the facility or personnel.

In the case of *Greater Glasgow Health Board v Doogan and Another* (Scotland),[793] the respondents (midwives) had requested to be excluded from being part of the treatment of any patient admitted for pregnancy termination. Their employers objected on the grounds that there were a limited number of personnel to care for all patients admitted for pregnancy termination. The employer argued that the respondents will not be part of the termination but must care for the patients before and after the termination. The lower courts upheld the objection of the respondents, but the employers appealed to the Supreme Court.

790 NHS Act 2009 section 3 http://www.legislation.gov.uk/ukpga/2006/41/contents (Date of use: 6 February 2019).

791 https://www.rcn.org.uk/get-help/rcn-advice/refusal-to-treat (Date of use 15 June 2019).

792 These laws make provision for conscientious objections: Section 4(1) of the Abortion Act 1967 (Scotland, England and Wales) [in cases of termination of pregnancy] and Section 38 of the Human and Fertilization and Embryology Act (1990) [in cases of technological procedures to achieve conception].

793 [2014] UKSC 68.

The Supreme Court held that the midwives ought to care for the patients until the termination procedure commenced, at which point, they may handover to another competent person, with proper handover notes. The court had to weigh the rights of these patients to be treated in a medical facility, against the discrimination against midwives with a religious aversion to pregnancy termination.[794] The court opined that there must be some compromise from both parties. If not, patients eligible for pregnancy termination will be refused treatment by facilities on the grounds that there are no members of staff to care for them, which will be a failure on the part of the NHS. Yet, they may also not discriminate against nurses. Considering the above, it appears that the availability of resources on the part of the NHS has an influence on medical care.[795]

An NHS patient also has the right to receive the care and treatment appropriate to his/her needs and suited to his/her preferences. Where a patient's preferences cannot be honoured, adequate explanations of the impact must be provided and alternatives must be explained, so that the patient can make an informed decision. This right is based on the "person-centred care"[796] which must be appropriate, meet their needs, and reflect their preferences. Person-centred care is ideal; however, the realities show that from the early days of an attempt by the Charter to reduce patient treatment waiting times to a maximum of two years, till date,[797] patients are only given care that is available within their NHS Trust and their finances. It seems that only general and discretionary duties are given to the patients,[798] save and except if they can afford private healthcare. To make care patient-centred, the following questions must be asked and answered succinctly: what type of care is provided? Where is it provided? By whom is it provided?

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794 [2014] UKSC 68.

795 *R (on the application of G) v Barnet London Borough Council* [2003] UKHL 57.

796 Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 https://www.cqc.org.uk/sites/default/files/20150510_hsca_2008_regulated_activities_regs_2104_current.pdf (Date of use: 6 of February 2019).

797 Baddeley P "A Doctor's View" in Tschudin V (ed) *The Patient's Charter: Ethics* (Scutari Press London 1995) 51.

798 *R v North and East Devon Health Authority ex parte Coughlin* [2001] QB 213,230.

When is it available? At what cost to the patient? These will help to achieve some standard of care which shall be no better or worse than is generally available.[799]

The right to access health services imposes upon the patient a duty to be involved in his/her care. To achieve this, there should be adequate and effective communication between patients and their caregivers.[800] The National Institution for Care and Excellence (hereafter "NICE") has made recommendations on the communication between service providers and their patients in line with the Care Act.[801] The Care Act includes the oversight of a local authority in the area where the patients live, incorporating wellness checks for geriatrics, as well as after-discharge support for patients. This ensures that there is a connection between government and patients for their overall wellbeing in their private residences, or at the hospital.

NICE recommends setting up systems of support for the patients, offering them personalized care and:[802]

- delivering services that are person-centred and focused on recovery.
- ensuring effective communication between care teams and patients.
- co-producing a comprehensive care plan that meets patients' needs.

For patient suited preferences and the avoidance of paternalistic medicine, it is pertinent that patients should be spoken to in languages they understand and in a medium they can relate with. Simplified words should be used for understanding and it is advisable that the most important information is given first. Patients should also be asked open-ended questions, so they can air their concerns with no restrictions.[803] Where a patient cannot be treated, information support should be given as a right.[804] The NHS owes it to patients that access to healthcare

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799 Ziegenfuss J T *Patients' Rights and Professional Practice* (Van Nostrand Reinhold Company New York 1983) 93.

800 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582, *Chester v Afshar* [2004] UKHL 41.

801 Care Act 2014 sections 3, 6, 7, 22, 23, 74 and schedule 3 http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf (Date of use: 15 June 2019).

802 https://www.nice.org.uk/guidance/ng53/resources/tailored-resources-4429245855/chapter/Introduction (Date of use: 15 June 2019).

803 https://www.ncbi.nlm.nih.gov/books/NBK115230/pdf/Bookshelf_NBK115230.pdf (Date of use: 15 June 2019).

804 *Open Door Counselling and Dublin Well Woman v Ireland* (1992) 15 EHRR 244.

services is easy and waiting time is within the stipulated schedules stated in the Handbook to the Constitution.[805]

5.3.2 The right to quality of care and a clean environment

This right denotes that patients must be treated with reasonable and professional care by the NHS staff.[806] The staff must have the necessary professional experience and qualifications. Reasonable care and skill from NHS staff is gauged by the requirements of the professional practice. Where there is a breach of this right to quality care, the patient is entitled to damages. Persons who carry out regulated activities in England must be registered with the CQC and meet the minimum standards of safety and care. The CQC inspects and regulates these service providers to ensure they never fall below the standard.

Patients have the right to be cared for in a clean, safe, secure and suitable environment. The ambience and environment of the healthcare facility is critical for the physiological and emotional wellbeing of a patient. It is required that the premises be clean and that the staff designated to maintain the cleanliness of the environment be adequately trained to maintain same within the right protocols.[807] In the case of home-based care, the health workers may not be responsible for the state of the patient's home, but may raise reservations/complaints on parts of the home which fall under the care of the health worker, as it relates to the patient's treatment. A clean and safe environment is wholesome for the patient and the personnel caring for them.[808] Maintaining proper hygiene is also necessary in eliminating patient-to-patient, or patient-to-carer transmission of infectious diseases. In the healthcare facility, this includes cleaning surfaces, decontaminating equipment and other items used in patient care, proper disposal of sharp items, safe handling of linen and cloths, safe handling of waste, and the

805 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770675/The_Handbook_to_the_NHS_Constitution_-_2019.pdf (Date of use: 21 June 2019).

806 NHS Act 2006.

807 The HSC Act 2008 (Regulated Activities) Regulations 2014 regulations 12, 15 and 17.

808 Clarke SP and Donaldson NE "Nursing Staffing and patient care quality and safety" in Hughes RG (ed) title? (Agency for Healthcare Research and Quality United States 2008).

control of the microorganisms in the water and ice used in the course of treatment.[809]

A secure environment is one kept safe to avoid unintended or unexpected mishaps to patients during the term of their treatment and recuperation. The NHS actively supports service providers to ensure improvements in safety and quality and to reduce safety incidents via the National Patient Safety Collaborative (hereafter "NPSC"). The agency raises awareness of the need for a culture of safety in healthcare facilities. Additionally, it promotes avoiding harm to patients by improved recognition and early warning systems.[810]

As part of quality care, patients have the right to receive suitable, nutritious food and hydration to sustain good health and wellbeing. To ensure this, mealtimes must be secure with no distraction and adequate assistance given to patients who need support to be fed.[811] The nutritional needs of patients must also be reviewed regularly.[812] It is essential that food and hydration are not only provided, but also administered to the patient, to avoid malnutrition of patients who are unable to take in adequate quantities by themselves as malnutrition will deplete a patient of the vitamins, proteins, minerals, and energy required for recuperation.[813] This is reported to cost the UK economy 19 billion pounds a year.[814] Good nutrition and hydration are part of the standards set by the CQC and on which a health facility is rated when supervised.[815] All patients admitted

809 https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/prevention+and+management+of+infections+in+healthcare+settings/environmental+hygiene+in+healthcare#ControlofLegionellainwaterandicemachines (Date of use: 16 June 2019).

810 https://improvement.nhs.uk/resources/patient-safety-collaboratives/ (Date of use: 17 June 2019).

811 The HSC Act 2008 (Regulated Activities) Regulations 2014 regulations 9, 14 and 17.

812 The HSC Act 2008 (Regulated Activities) Regulations 2014 regulations 9, 14 and 17.

813 Anderson L "Assisting patients with eating and drinking to prevent malnutrition" https://www.nursingtimes.net/clinical-archive/nutrition/assisting-patients-with-eating-and-drinking-to-prevent-malnutrition/7021578.article (Date of use: 16 June 2019).

814 https://www.bapen.org.uk/pdfs/economic-report-full.pdf (Date of use: 16 June 2019).

815 https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards (Date of use: 16 June 2015).

for healthcare have to be screened for nutritional needs within the first 24 hours.[816]

The National Quality Board (hereafter "NQB") is the agency responsible for safeguarding and improving the quality of service and equipment in the NHS.[817] The Board ensures that the quality of care provided to patients is not compromised by management pressures within the organizations in charge of the healthcare facilities. The organizations need to put the interests of the patient first, when making decisions. The first step in providing quality care is receiving patients' feedback and acting on it. It is acknowledged that no system is 100% fool proof, but there must be steps in place to be taken when failure occurs.[818]

There are three dimensions to quality, namely clinical effectiveness, patient safety, and patient experience. The clinical effectiveness must be of a standard that improves the health outcomes of the patients. A patient's experience must be positive and wholesome with regards to meeting his/her needs and protecting his/her dignity and self-respect.[819] Under these dimensions, the following parameters must be used to assess the outcomes:

- patients ought not to die prematurely;
- the quality of life of patients with long term conditions must be maintained;
- recovery from the effects of temporary ill health or injury must be assured;
- patients should have a positive experience during their term of care; and
- the environment must be clean and safe, and patients should be protected from avoidable harm.

The CQC, which is discussed below, has powers to mandate improvements from providers or sanction them. Systems have been put in place to measure the effectiveness of treatment and adjust it as required. This measurement is done

816 NICE "Nutrition support for adults: oral nutrition support, enteral tube feeding and parental nutrition clinic guideline [CG32]" 32. https://www.nice.org.uk/guidance/cg32/chapter/1-Guidance (Date of use: 16 June 2019).

817 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf (Date of use: 17 June 2019).

818 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213304/Final-NQB-report-v4-160113.pdf (Date of use: 17 June 2019).

819 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/ file/213304/Final-NQB-report-v4-160113.pdf (Date of use: 17 June 2019).

by the Outcomes Framework at the national level and they measure the following:[820]

- Effectiveness of care

  Domain 1: The prevention of premature death.

  Domain 2: The enhancement of the life of those with long term health conditions.

  Domain 3: Assistance with recovery after ill-health or injury.

- Patient experience

  Domain 4: To make certain that patients experience care in a positive way.

- Patient safety

  Domain 5: To treat patients in a safe environment that protects them from avoidable physical injury.

Quality improvement for the NHS is anchored on resolving unwarranted variations in clinical care, reduction of waste, focus on patient-carer oriented service and sustenance of safety and quality at an optimal level.[821]

5.3.3 The right to nationally approved treatments, drugs and programs

Treatments, medications and other procedures are regulated by NICE. NICE is an independent organization that carries out highly technological appraisals and technical assessments of medications and procedures. If NICE has recommended a treatment or drug for a diagnosis, the relevant authority[822] must use that drug or treatment to treat the specific diagnosis.[823] Once medication for a specific diagnosis has been approved, a patient has the right to that medicine if the doctor prescribes it. If the local NHS Trust cannot fund a drug or treatment which the doctor of a patient believes will be appropriate, the patient has the right to be given reasons for such refusal to fund the medicine.

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820 National Health Service Act 2006 (as amended by the HSC Act 2012) sections 13D, 13E, 14S.

821 Alderwick H et al *Better value in the NHS: The role of changes in clinical practice* (The King's Fund 2015) 10.

822 CCG, NHS England or a local authority.

823 The National Institute for Health and Care Excellence (Constitution and Functions) regulation 7; The Health and Social Care Information Centre (Functions) Regulations 2013 regulation 8.

Similarly, vaccinations and other inoculations approved by the Joint Committee on Vaccination and Immunisation (hereafter "JCVI") are to be provided for NHS patients who meet the requirement with adequate arrangements made by the Secretary of State; this grants an enforceable right to all patients.[824] The Secretary of State has an obligation to ensure that the recommendations of the JCVI reaches the beneficiaries. The patient is also entitled to screening by the UK National Screening Committee.[825]

5.3.4 The right to respect, consent and confidentiality

Patients have the right to be treated with respect and dignity in line with their human rights.[826] This includes the right not to be subjected to inhuman or degrading treatment. Patients must be protected from suffering or other procedures that permit abuse or neglect. Allegations of abuse by patients must be taken seriously and where proven, redress must be obtained and the abuse, prevented from reoccurring.[827]

Confidentiality is necessary in healthcare because patients need to trust the attending health workers not to make their information easily accessible or deliberately release it.[828] Where there is lack of trust, patients may not access healthcare and if they must, may not reveal all the necessary details about their ailment to the attending physician.[829] Confidentiality is a legal and ethical duty of the healthcare worker to the patient but it may not be absolute.[830] Where a patient's information is to be used for education and training, it should be anonymized.[831] If the information is required for insurance or employment

824 Health Protection (Vaccination) Regulations 2009.
825 NHS (England 27 July 2015) 8. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS_Constitution_WEB.pdf (Date of use: 30 December 2019).
826 The European Convention on Human Rights (ECHR) articles 2, 3 and 8.
827 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 regulation 13.
828 Hogg C *Patients, Power and Politics: from Patients to Citizens* (Sage Publications Ltd New York1999) 20.
829 *Attorney-General v Guardian* (No 2) [1990] 1 AC 109.
830 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years/~/link.aspx?_id=50F3C6C1F6294B5DB6E6F9EA54117D0E&_z=z# (Date of use: 17 June 2019); *Campbell v Mirror Group Newspapers* [2004] UKHL 22.
831 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---disclosing-for-education-and-training-purposes (Date of use: 17 June 2019).

purposes, the patient must be fully aware of the purpose of the examination and there should be written consent from the patient for the disclosure.[832]

If a communicable disease is diagnosed which under statutory law requires disclosure, the physician shall disclose only information which are relevant. But if the disclosure is for the protection of others and not required by statute,[833] the physician needs the consent of the patient to disclose it. Gunshot or knife wounds should be disclosed to the Police for crime investigation and to protect the public interest.[834] For media trials and accusations, a physician needs the explicit consent of his patients before divulging any confidential information to the media.[835]

A breach of confidentiality may earn sanctions, which include discipline by the General Medical Council[836] or the appropriate regulator for the health worker; civil proceedings with punitive compensation payable to the patient; or criminal proceedings.[837] In 2017, accusations were made against the NHS in a suit against the Home Office, for releasing patients' details to the Home Office for immigrants' tracking.[838] Thereupon, the secret file sharing between the NHS and the Home Office was stopped. A spokesperson for the Home Office said the data sharing will be restricted to non-medical information going forward.[839]

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832 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---disclosing-information-for-employment-insurance-and-similar-purposes/disclosing-information-for-employment-insurance-and-similar-purposes (Date of use: 17 June 2019).

833 *R v Department of Health ex p Source Informatics Ltd* (2000) 1 ALL ER 786.

834 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---reporting-gunshot-and-knife-wounds/reporting-gunshot-and-knife-wounds (Date of use: 17 June 2019).

835 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality---responding-to-criticism-in-the-media (Date of use: 17 June 2019).

836 Marsh H and Reynard J "Patient confidentiality: ethical. Legal and regulatory responsibilities" 2009 *BJUI* 104, 164-167.

837 https://ministryofethics.co.uk/index.php?p=6&q=7 (Date of use: 18 June 2019.

838 Bulman M "NHS accused of breaching doctor-patient confidentiality for helping home office target foreigners" https://www.independent.co.uk/news/health/home-office-nhs-data-sharing-patients-human-rights-court-challenge-a8045011.html (Date of use: 17 June 2019).

839 Bowcott O "Home office scraps scheme that used NHS data to track migrants: Secret data-sharing deal dropped after legal action by migrants' rights network" https://www.theguardian.com/society/2018/nov/12/home-office-scraps-scheme-that-used-nhs-data-to-track-migrants (Date of use: 17 June 2019).

5.3.5 The right to informed choice

Patients have the right to consent to treatment except if they fall under the exclusion regarding psychiatric patients.[840] This means that physical examinations and treatment procedures are not to be carried out on patients who have not given consent for it. Where a patient cannot consent due to mental incapacity, (s)he may assign another to exercise this consent on his/her behalf upon a power of attorney. Where the power of attorney is not in place, the medical practitioner may exercise his/her power to take this decision as provided for in the Mental Capacity Act.[841] If it is a serious decision, the court may need to make an order on behalf of the patient.

Obtaining informed consent before treating a patient is a legal and ethical duty for all healthcare workers. For consent to be valid, adequate information must be given to the patient. The patient must give consent voluntarily and the patient must have the capacity to give the said consent. Consent may be given verbally or in writing, but it is advisable to put it in writing. In situations involving surgeries that are not emergencies, consent must have been secured well ahead of the operation.[842]

The word “informed” denotes that adequate explanation would have been given to the patient on the type of physical examination or type of medical procedure intended to be carried out on him/her. The information should be clear and explained via a medium the patient will understand. Patients should be informed of all possible options of treatment available. A healthcare professional who gives insufficient information will be guilty of a breach of the duty of care and the patient will be entitled to compensation. Patients also have the right to access their records and correct any incorrect information entered therein.[843]

5.3.6 The right to involvement in their healthcare in the NHS

Patients have the right to be involved in their healthcare. The patient should be given all necessary information to exercise this right. This includes planning

840 Under the Mental Health Act 1983.
841 2005 (c 9).
842 https://www.nhs.uk/conditions/consent-to-treatment/ (Date of use: 17 June 2019).
843 The Data Protection Act 2018 schedule 2.

according to a personal health budget[844] where it is applicable. This right is based on the person-centred care which seeks to address what matters to the patient.[845] All essential services which a patient must receive by regulation are also to be discussed and planned with the patient.[846] Doctors at the primary and secondary care level are required to work with patients to ensure satisfactory care.[847] This right dovetails into informed consent as discussed earlier. Patients should be told of any risks relating to their care, as personal information and records may be crucial to private and family life.[848] Involving patients in their own healthcare denotes serving them with a focus on what matters to them, not just a diagnosis and treatment approach. The patients need to be given adequate information that ensures the outcome of their healthcare matters and is connected to their expectations. Furthermore, within the ambits of this right, all information and support the patient needs to scrutinize his treatment process must be provided to him/her. The patient's family members, representative or carers should be allowed to partner with the NHS for the patient's treatment. The patient should be involved in discussions about his/her treatment and be offered a written record of the treatment procedure agreed upon. The patient's feedback on the experience and treatment should also be encouraged by NHS.

5.3.7 The right to complaint and redress

Patients have the right to complain about NHS services and such complaints should be acknowledged within three business/working days.[849] The complaints ought to be investigated and a response given to the patient. The approach to be adopted to resolve the complaints should also be discussed with the patient.[850] The progress of the investigation of the complaints should be given to the patient

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844 The NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendments) Regulations 2013, Part 6A.

845 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 9 of.

846 The NHS (General Medical Services Contracts) Regulations 2004, Regulation 15.

847 http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp (Date of use: 1 April 2019).

848 *Gaskin v United Kingdom* (1989) 12 EHRR 36; *Mersey Care NHS Trust v Ackroyd* [2006] EWHC 107.

849 Local Authority Social Services and National Health Service Complaints England Regulations 2009 and NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Health watch) Regulations 2012 part 5.

850 NHS Constitution Section 3a.

in time and the anticipated time of completion should be communicated to the patient. Upon conclusion of the investigation, the patient has a right to a report. Despite this stipulation, it has been reported that the complaints' mechanism is flawed[851] particularly because most times when there are complaints, decisions are given in favour of the health institution and the patient has no sense that justice was done. This has been attributed to the active involvement of the health services in various stages of addressing complaints, making them judges in their own cases, against the laws of natural justice.

The complaints procedure was established in 1996 with two stages, commencing with a local resolution process which may be escalated to an independent review where there is dissatisfaction with the decision. Where patients' attempts to escalate to an independent review have been rejected or patients are dissatisfied with the independent review, they may refer their grievances to one of the UK's Health Services Ombudsmen. Complaints should be made within six months of occurrence or a good reason for delay given.[852]

Statistics indicate that between 2000 and 2001, the NHS in England received one hundred and forty thousand, four hundred and thirty-six written complaints but only three thousand, five hundred and eighty-five complaints were put forward for investigation and independent review. Some of the complaints which did not progress to this point, were sent back to local resolution or rejected.[853] Reports on the complaints received between 1 October 2018 and 31 December 2018, indicate that there were twenty-eight thousand and nineteen new complaints received. Of that number, twenty-seven thousand, six hundred and seven complaints were resolved with only nine thousand, two hundred and nine (33.4 percent) found to be valid and nine thousand, eight hundred and seventy-seven (35.8 percent) were found to be invalid complaints deserving no resolution.[854]

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851 Elder J *Fair Play and Foul? A book of revelations about patients' rights, complaints handling and compensation in the United Kingdom and elsewhere in Europe* (Klaxon Books Chepstow 2005) 1.

852 Elder *Fair Play and Foul?* 3.

853 Department of Health, Written Complaints About Hospital and Community Health Services by Services Area, England, 2002- 03 as used in Elder *Fair Play and Foul?* 5.

854 https://files.digital.nhs.uk/1E/A86A74/Data%20on%20Written%20Complaints%20in%20the %20NHS%202018-19%20Q3%20Report.pdf (Date of Use: 20 June 2019).

The outcomes of the investigations may be appealed to the Health Services or Local Authority's Ombudsman.[855] All the NHS or public health complaints procedures must have been exhausted, with the exceptions of few cases, before audience can be given to the patient at the Ombudsman. If still dissatisfied, the patient may apply for a judicial review based on the UK's administrative laws. If the investigations reveal negligence, the patient has a right to compensation.

Flowing from this right, the NHS owes a patient the duty of courteous interaction throughout the complaint procedure, and patients who have complained must not be victimised in the future.

It is pertinent to note that one of the challenges of patients' rights actualization is the enforcement of patients' rights in courts of law. The next subsection shall assess some relevant and recent cases which have bordered on the rights of patients. The subsection on selected case law affirms that patients' rights exist in the laws, but the majority of cases rely on the health practitioner to determine whether a patient's right has been breached. Importantly this subsection puts what the NHS Constitution and other laws have provided for in practice.

5.4 Selected case law on patients' rights in the UK

Patients in the UK have a right of redress where they believe their rights have been infringed upon. Courts, the Fitness to Practice Panels of the General Medical Council, local NHS reporting mechanisms, the CQC and other bodies have been a source of succour. The cases in courts have been of great advantage because they have been able to preserve the facts and details of patient infringement and the court's method of protection. A few of these cases are examined below in a bid to highlight the extent of protection available to patients in the UK.

5.4.1 Michael Darnley in Darnley v Croydon Health Services NHS Trust[856]

The judgement in this lawsuit was given in 2018. The appellant suspected he sustained a head injury when an object hit him on his head. He called his friend

855 Health Service Commissioners Act 1993 and the Local Government Act 1974.
856 [2018] UKSC 50.

to take him to the Accident and Emergency (A&E) unit. The receptionist refused to treat him as an emergency and told him that he may need to wait for hours before being attended to. This information was denied during the trial by both receptionists on duty at that time. The claimant left the hospital to get an analgesic at home after waiting for a few minutes. He took a nap, woke up in distress, and by the time an ambulance returned him to an A&E unit, he had to undergo surgery to remove a hematoma from his brain. As a result, he developed permanent brain damage in the form of very disabling left hemiplegia.

The trial Judge asserted that waiting was normal at the A & E unit and the receptionists were not to be blamed for not treating the claimant as an emergency, since he had no visible signs of distress. Further, he had been told to wait for the triage nurse, yet he left after 19 minutes. At the Appeal Court, the court upheld the decision of the trial judge, stating that the receptionists owed him no duty beyond asking him to wait for the triage nurse, since he showed no visible signs of distress. At the Supreme Court, the court emphasised the novelty of this case in the issue of a duty of care at a health facility and queried the decisions of the lower courts.

The Supreme Court cited the decision of the court in *Barnett v Chelsea and Kensington Hospital Management Committee*[857] where it was said that the staff of a casualty unit owes the duty of care to persons who present themselves with an injury, before the patient is admitted for treatment. It was also held that the personnel at the casualty ward owed a duty to prevent harm to the patient. The duty not to cause harm to the patient also infers that the words of the staff should not cause harm to the patient. The court held that even though this case was unprecedented, it was not out of place to categorise it with similar cases where the court had decided that there was a duty of care.

The Supreme Court further stated that in assessing whether there is a duty of care to cause harm or not, there should be no distinction between medical or non-medical personnel. Since the healthcare facility had charged the non-medical staff to be the first interface with a patient, they were under a duty not to give

857 [1969] 1 QB 428 435-436.

misleading information. The Supreme Court also cited *Kent v Griffiths,*[858] where a London ambulance service was held liable for negligence for not responding timeously to a patient's call, with the result that the patient developed a brain injury. In the *Kent's* case, even the phone handler was indicted for misleading the patient with the words that 'the ambulance would arrive shortly". The acceptance of the call imposed a duty of care on the personnel. If he had not been misled as to the time of arrival of the ambulance, the patient would have sought other means of transport to the hospital.

The Supreme Court asserted the Appeal Court's observation that if the patient had been told to wait for 30 minutes as should be the case, he would not have left after 19 minutes. If he had waited for at least 30 minutes, his collapse would have occurred on the hospital premises. The Supreme Court concluded that the decision of the Court of Appeal was contrary to this finding. The Supreme Court allowed the appeal and ruled that the patient should be awarded compensation for damages.

This case underlines the issue of the role of non-medical personnel in a healthcare facility. The duty of care owed to a patient is all round and not limited to the medical personnel only. This affirms the right of the patient to receive care and be treated in a manner appropriate to his/her needs.

5.4.2 Montgomery v Lanarkshire[859]

This is a 2015 case which touches on the issue of giving all the information necessary for the patient to give informed consent for treatment. Before this case, the *Bolam t*est had been the measure used to gauge the level of information required to be given to patients. The test posited that the standard of care a doctor owes his patient is subject to medical judgement.[860] The medical judgement is the standard to be set by the professional body. The learned court in *Montgomery v Lanarkshire*[861] under consideration, overruled the *Bolam* test. The claimant sued the physician for failing to tell her of the risk of shoulder dystocia. When a

858 *Kent v Griffiths* [2001] QB 36.
859 [2015] SC 11 [2015] 1 AC 1430.
860 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
861 [2015] SC 11.

diabetic woman gives birth to a large baby through the birth canal, the size of such a baby can cause complications such as shoulder dystocia as it passes through the birth canal. The shoulder will be the problem as it will be unable to pass through easily. In this case, the claimant's baby's shoulder got stuck during the birth process and as a result, her baby suffered severe disabilities.

The court of first instance held that there was no negligence, because there were contra-indications for a caesarean section for the woman which would have discouraged her from undergoing the surgery to birth her baby even if she knew about the risk. At the Supreme Court, however, the judge upheld the need for adequate disclosure before genuine informed consent. The Court stated that applying the *Bolam* test to this case would be subjecting the patient's right to information to the opinion of the physician on what should be said and what should be withheld. The Court further stated that except for situations where the patient expressly says (s)he does not wish to be told, and where the doctor considers that telling the patient will cause hardship to the patient, information should not be disclosed.

This case is a positive development in the assertion of the right to informed consent. The assumption that the patient who was not a prime candidate for a caesarean section would probably not have done the surgery even if she was aware of the risk of shoulder dystocia to her baby, was certainly not enough reason not to tell her. From a relative angle, informing the patient of the risk might have opened realistic discussions on making the process or the optional surgery safer. The patient in question was denied that opportunity because the doctor felt protected by the *Bolam* test. Overruling the *Bolam* test will make the doctors treat each case separately and not treat patients based on stereotypical assessments, which would amount to a breach of their right to informed consent.

5.4.3 Great Ormond Street Hospital v. Gard[862]

In 2017, Charlie Gard, a 9-month-old baby was being treated for encephalomyopathic mitochondrial DNA depletion syndrome (MDDS), a congenital illness, at an NHS Trust hospital. His treatment caused progressive

862 2017 EWHC 972 (Fam). (No. FD17P00103 Royal Courts of Justice, 11 April 2017).

brain damage and muscle failure. He was admitted for failure to thrive. A few months into the admission, Gard had seizures that caused brain damage and the hospital believed that any further treatment would be futile. The hospital advised the parents to withdraw the life support and commence palliative care. A doctor in New York recommended nucleoside therapy. Gard's parents raised funds to transfer the infant to New York and the hospital (respondent) applied to court to override the parent's decision. The court upheld the application and the parents appealed to the Court of Appeal, the Supreme Court and the European Court of Human Rights. The decision of the court of first instance was upheld at all the appellate courts. The hospital later got letters from authorities supporting the recommended treatment upon which the hospital sought to overturn the court's decision. The doctor in New York, Dr Hirano, was invited to assess the child, but Hirano said it had become too late to treat him. The parents then agreed to withdraw life support and the infant passed away the following day.

The Judge at the court of first instance had cited Lord Donaldson in *Re J*[863] where the learned Judge said even though there is a presumption in favour of prolonging life, there needs to be the assurance that it will be in the best interests of the patient and not result in making him suffer for longer. In the case of Gard, the US doctor had agreed that the treatment he recommended had never been tested on humans or animals for the congenital condition Gard had and that the seizures had left his brain damaged beyond repair.

The Judge at the court of first instance referred to *Airedale NHS Trust v. James* and *Airedale NHS Trust v. Bland*[864] where the learned court explained that the patient must be considered as a person, and not as a social or medical experiment. The Judges should put themselves in the patients' shoes and consider if the treatment will be able to resolve the issue or prolong his suffering. This would go against the physician's primary duty to the patient as captured in the Hippocratic Oath, to "first do no harm", which will be the case if the child in his/her suffering is subjected to an experimental treatment.

863 *Re J (A minor) (Wardship treatment*) [1991] Fam 33 at 46.
864 *Airedale NHS Trust v. James* [1993] UKSC 67 and *Airedale NHS Trust v. Bland* [1993] AC 789.

The case queries the extent to which the right to health supports the right to life. The right to life cannot be considered devoid of the existence of positive wellbeing. The right to health should be to reduce suffering and make the patient's life better, even if it cannot cure him, but where the right to health will cause untold suffering, then it may be suspended, and nature allowed to have its way.[865]

5.4.4 Spencer v Hillingdon NHS Trust[866]

The claimant was admitted for the correction of a hernia in his right groin. The procedure adopted was a laparoscopy, but midway through the procedure, visibility was hindered, and the patient had to be opened. After his discharge, he developed deep vein thrombosis (hereafter "DVT"). The claimant sued, because he was not made aware of this risk, even though he was told of the possibility of switching to open surgery if there were issues with the laparoscopy. The doctor's defence was that DVT rarely occurred, so the hospital personnel did not want to scare the patient away from the open surgery for no reason.

This was the first case in which the decision against the *Bolam* test in *Montgomery v Lanarkshire* was tested. The NHS defended the medical practice with the position that immaterial information need not be given to patients, but the court opined that as held in the *Montgomery* case, materiality should be adjudged based on the nature of the risk, the likely effect of the risk on the patients' life, the importance of the benefit to the patient, and the alternative treatments available along with their risks. The *Montgomery* case insists that the court takes the patient's point of view into consideration too.

The claimant (Mr Spencer) said the nurse did not tell him of the signs and symptoms to watch for and the physician never brought up DVT as a risk. Moreover, NICE had just released Clinical Guideline (hereafter "CG") 92[867] which is on DVT, before the claimant's operation. The Clinical Guideline 46[868] which was in place before CG 92 expressly mandates the physician to inform patients

865 *R (on the application of Purdy) v Director of Public Prosecutions* [2009] UKHL 45.
866 [2015] EWHC 1058 (QB).
867 Now updated to NICE guideline NG89 https://www.nice.org.uk/guidance/cg92 (Date of use: 23 June 2019).
868 NICE clinical guideline 46, 9 http://www.spitalmures.ro/_files/protocoale_terapeutice/chirurgie/reducerea_riscului_de_embolie_la_pacientii_chirurgicali.pdf (Date of use: 23 June 2019).

whose treatment bears the risk of DVT; this was repeated in CG 92. While CG 46 refers to patients that stand a high risk, this category did not apply to the claimant. CG 92 requires an assessment to ascertain if the patient is at risk.

The judge further stated that even though the guidelines are not a basis on which to accuse the hospital of negligence, considering the position of NICE from CG 46 to 92 in a bid to drastically reduce death by DVT, it is expected that a "modern, safe and responsible medical practice" will inform patients of the signs and symptoms of such, if they stand any risk of developing it. In this instance, the court found the respondent negligent and awarded the claimant damages.

5.4.5 R v Cambridge Health Authority, Ex parte B

Jayme Bowen was diagnosed with non-Hodgkin's lymphoma at the age of 6 in 1990 and received treatment. In 1993 she was diagnosed with acute myeloid leukaemia and was treated with chemotherapy and a bone marrow transplant. Nine months later, she relapsed. The doctors recommended palliative care and gave her a few weeks to live. Her father did his own research and found American doctors who recommended another bone marrow transplant. Jayme's paediatrician insisted that palliative care would improve her life. Her father approached the Cambridge Health Authority to pay for the treatment.

The Health Authority decided to adopt the paediatrician's prescription. Her father obtained a High Court order to request the Health Authority to reconsider its position. The High Court held that the Cambridge Health Authority, which denied treatment to a patient because of limited resources, needed to spell out the proper considerations that led to the denial. Limited resources were not good enough to breach the right to life.

On appeal, the Appellate Court stated that "we do not live in a utopic world where all needs can be attended to". The medical needs of patients need to be prioritized and in this case the patient's prognosis was such that may not respond to treatment, so the Health Authority was right to deny treatment on the grounds of limited resources. The media condemned the Appellate Court's judgement. A

private donor funded Jayme's treatment, but she subsequently died a few months later. Her father felt vindicated nonetheless.[869]

5.4.6 R (Rodgers)v Swindon NHS Primary Care Trust[870]

Ms Rodgers' physician prescribed Herceptin for the treatment of her HER2 breast cancer on a private arrangement. NICE had not licensed treatment at that time but the European Medicines Agency (hereafter "EMEA") had licensed it for late-stage cancer. The patient applied to the NHS Primary Care Trust (hereafter "PCT") to fund it, but her request was declined on the grounds that it must meet the criteria of an "exceptional diagnosis", to be approved, and her diagnosis was not. The patient could afford only two doses which she brought before the judicial review to reverse the decision of the PCT on grounds of irrationality of the decision and a breach of her right to life and right against discrimination.[871] The court of first instance upheld the position of the PCT, but on appeal, the Appellate Court held that the decision was indeed irrational as the "exceptionality clause" was meaningless on the basis that:

> Where the clinical needs are equal, and resources are not an issue, discrimination between patients in the same eligible group cannot be justified on the basis of personal characteristics not based on healthcare.[872]

One factor that resonates through this case is that when the position of the NHS Constitution is clearly spelt out, there must be rational and precise reasons for such a deviation by the NHS PCT or any other Health Authority. A perceived breach of a patient's right will remain a breach until the NHS can show valid reasons for the breach.

The advantage of *stare decisis* means that some of the court decisions have become sources of practice guidelines and a regulatory framework for professions. Some cases have been identified based on their peculiar nature and the decisions given as regards to patients' rights in the UK. While this is not an exhaustive list, it assesses recent patient rights' related decisions which may

869 Ham 1999 *British Medical Journal* 1258 -1261. (first time???)
870 [2006] EWCA Civ 392.
871 Article 2 (right to life) and Article 14 (Prohibition of discrimination) of the European Convention for the Protection of Human Rights and Fundamental Freedoms.
872 [2006] EWCA Civ 392.

become of significant relevance for the protection of patients' rights now and in the future, in the UK. In *Darnley* the courts were able to widen the scope of responsibility for patients, restating the role of every member of the healthcare community especially in emergency cases.[873] The court also affirmed in *Barnett v Chelsea*[874] when a person becomes a patient and the responsibility of emergency and ambulance services to patients. In *Montgomery v Lanarkshire*[875] the courts affirmed the right of a patient to informed consent, trumping the *Bolam* test and emphasising the right of the patient to true informed consent. In *Great Ormond v Gard*,[876] there is a different dimension to the patients' rights discussion as the patient was a child, and parents were making decisions on behalf of the patient. This perspective raises new issues as a child cannot make valid decisions, hence the best interest test. The courts upheld the hospital's position to withdraw life sustaining treatment against the wish of the parents. Cases like this bring to fore the question as to whether patients who do not have capacity are truly being treated on the best interest basis or paternalistic decisions of doctors. This thesis in upholding the right of patients who lack capacity, especially children, posits that patients' relatives' decisions should be weighed strongly against best interest decisions and courts should take a balanced view as they have done in *Gard*. Nonetheless, it is obvious that patients' rights protection is higher in the UK than in other jurisdictions considered in this research.

It worthy of note however, that litigation is not the only option available to patients, although recourse may be made to the courts. This is because the NHS tries to settle confirmed cases of medical negligence outside the walls of the courtroom. This is discussed below.

5.5 NHS and patients' indemnity for clinical negligence

The NHS has in place a program called the Clinical Negligence Scheme for General Practice[877] (hereafter "CNSGP") that addresses the issue of negligence by personnel of healthcare facilities under the NHS. The program is administered

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877 https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-general-practice/ (Date of use: 20 June 2019).

by the NHS litigation authority. The legal principle applied to issues of medical negligence by NHS employees is the principle of vicarious liability under tort, because it is the NHS Trusts or other Health Authorities that have the legal standing to be sued, not the personnel who might have breached the patient's rights in person.[878] This excludes situations where the patient sought out the personnel's services in private.[879] The litigation authority is the special health authority that handles litigation or any other forms of dispute resolution against the NHS. The Authority also pays out damages when negligence is duly confirmed.[880] It has the duty to reduce the cost to the Trust with regards to potential, actual or alleged clinical liabilities of the NHS Trust and will pursue settlement without a court suit where possible. Their settlements must, however, be approved by court.[881]

The courts and the NHS (and her various institutions) are not the only bodies that work towards protecting patients' rights in the UK. One other body with a major influence on the protection of patients' rights in the UK is the CQC.

5.6 Care Quality Commission

The CQC is an independent regulator of social care and health in England. It is a non-departmental public body which was founded in 2008. Its primary duty is to protect and promote the health and welfare of those who use the health and social care services in the UK. The CQC has the obligation to encourage the improvement, the provision, and the efficient delivery of social healthcare services. The CQC achieves these objectives by regulating and setting the standards for the health and social services providers and inspecting those providers to ensure they adhere to the standard.
The CQC has fundamental standards, which stipulate[882]

- care and treatment must be tailored to a user's need and preference.

878 https://www.loc.gov/law/help/medical-malpractice-liability/uk.php#f28 (Date of use: 20 June 2019).
879 Department of Health, NHS Indemnity Arrangements for Clinical Negligence Claims in the NHS HSG (96)48, 1996. See https://resolution.nhs.uk/wp-content/uploads/2018/10/NHS-Indemnity.pdf (Date of use: 20 June 2019).
880 NHS, The National Health Service litigation authority: report and accounts 2008 9.
881 Litigation Framework Document in terms of the NHS Constitution.
882 https://www.cqc.org.uk/news/stories/our-fundamental-standards (Date of use 6th June 2019).

- patients must be treated with dignity and respect.
- the patient must give consent before any treatment or procedure is carried out on him or her.
- safety must be ensured in the implementation of all care and treatment.
- there should be no form of abuse or improper treatment of the patient.
- the patients' hydration and nutrition needs must be met.
- facilities and equipment to be used for treatment and care must be clean, secure and working properly.
- complaints must be heard, investigated and addressed through action or appropriate response.
- there should be systems and processes in place to ensure adherence to these fundamental standards.
- there should be enough adequately qualified and competent staff to attend to all patients.
- members of staff must be of good character, adequate qualifications and be able to carry out the tasks they were employed to do.

The CQC introduced a new approach to the inspection and regulation of NHS hospitals in 2013. The CQC also put in place a regulatory model to cover 2016 to 2021.[883] Under this new approach, the CQC protects users of the NHS by initially requiring improvement from service producers through warning notices. Where these are not complied with, the severity of the regulatory measure is increased to forcing improvement, by imposing conditions for registration or suspending or cancelling registration. Where there is no improvement by the indicted providers, they will be held accountable for their failures through criminal cautions for organizations or prosecution if an individual.[884]

The revised strategy for 2016 to 2021 is being implemented to achieve four objectives:

- to encourage innovation, improvement, and sustainability in care.

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883 Smithson *et al* "Impact of care quality commission on provider performance: room for improvement?" https://www.kingsfund.org.uk/sites/default/files/2018-09/cqc-provider-performance-report-september2018.pdf (Date of use: 10 June 2019).

884 Smithson *et al* https://www.kingsfund.org.uk/sites/default/files/2018-09/cqc-provider-performance-report-september2018.pdf (Date of use: 10 June 2019).

- to have an intelligence-driven approach to regulation.
- to promote a single shared view of quality.
- to improve its own efficiency and effectiveness.[885]

The objective is for the CQC to be able to predict the areas that should be focused on during inspection, based on the performance information captured in past and current inspections. This will allow the system to focus on the weak areas of providers and spend less time on inspections. The CQC is not in itself an improvement agency. The CQC diagnoses improvement needs, but other parts of the health system take up the task of ensuring that the providers improve.[886]

The CQC's processes seem to have several inefficiencies which constitute a spanner in the works of the health sector in the UK.[887] The inefficiencies led to the forced resignation of the first Chief Executive of the CQC after an investigation of a provider[888] revealed the abuse of persons with disabilities. The CQC was accused of not being able to police the healthcare providers enough.[889]

The CQC, among other regulators, is believed to be strategically positioned to influence the effect of healthcare decision making by institutions on patients. The watchdog strategy for institutional performance is shown to have prevented dangerous trends in management, including healthcare and resource management. Inspection and regulation of hospitals, a periodic term framework, and consistent reviews carried out by the CQC are important for the protection of patients' right to access health services, quality environment for adequate care, respect and confidentiality, as well as redress.

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885 Smithson *et al* https://www.kingsfund.org.uk/sites/default/files/2018-09/cqc-provider-performance-report-september2018.pdf (Date of use: 10 June 2019).

886 Smithson *et al* https://www.kingsfund.org.uk/sites/default/files/2018-09/cqc-provider-performance-report-september2018.pdf (Date of use: 10 June 2019).

887 Burton J "What's wrong with CQC? A proposal to reform the regulation of social care" https://www.centreforwelfarereform.org/uploads/attachment/534/whats-wrong-with-cqc.pdf (Date of use: 10 June 2019).

888 Winterbourne View hospital in Bristol.

889 Campbell D "CQC head David Behan: care has got safer and quality has got better" https://www.theguardian.com/society/2018/jul/11/cqc-david-behan-care-safer-quality-better (Date of use: 10 June 2019).

5.7 Rationing and patients' rights

The NHS was founded on a fallacy: namely the notion that there was a finite amount of ill-health in the population which, once removed, would result in the maintenance of health and the provision of healthcare becoming cheaper as the need for it dropped. What has happened is that success in healthcare has resulted in people living longer, potentially to be ill more often, and therefore consume more resources.[890]

Healthcare rationing is the allocation of healthcare resources to beneficiaries based on some indices of measurement of their level of entitlement or need. The National Institute for Health and Care Excellence (hereafter "NIHCE") is the government agency in the UK saddled with rationing healthcare to beneficiaries under the NHS. The cost effectiveness of the healthcare intervention per cadre of beneficiary and the quality of life lived *vis-a-vis* life expectancy is taken into consideration to determine the healthcare resources a beneficiary deserves. For example, obese persons and smokers may not be given priority for some treatments that patients who are healthier and stand a better chance of responding faster to treatment will get. *In-vitro* fertilizations, female sterilization, provision of gluten-free foods to allergic patients are some of the benefits impacted by a review of the rationing by the NHS.[891]

In a related paper[892] on low priority treatments in the London Borough of Haringey, Klynman stated that an assessment was done to establish the minimum and maximum potential savings of each primary care trust in London and that cutting back on procedures with limited clinical benefits across London could save the system £28m-£93m for 2005/2006. Moreover, some of these procedures were cosmetic and in line with medical views they are not always beneficial to patients. In 2009/10, Haringey spent roughly £2m on treatments on its low priorities list. In line with this list, the GPs are required to triage the patients

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890 Hunter DJ *Desperately Seeking Solutions: Rationing Healthcare* (Routledge 2017) 20.

891 Brennan S "NHS east and north Hertfordshire CCG: CCGs demand patients lose weight or face indefinite wait for surgery" https://www.hsj.co.uk/nhs-east-and-north-hertfordshire-ccg/ccgs-demand-patients-lose-weight-or-face-indefinite-wait-for-surgery/7020804.article (Date of use 9 March 2019).

892 Klynman N "Low priority treatments" http://dwhc.org.uk/wp-content/uploads/2010/12/Low-priority-treatments-for-overview-and-scrutiny-commitee-2.doc (Date of use: 9 March 2019).

and only refer patients with exceptional circumstances directly to the Individual Cases Panel at the Primary Care Trust.

The downside of rationing was captured in a BBC (British Broadcasting Corporation) report[893] where the Health Correspondent reported that hip and knee replacements and cataract operations, as well as medications for arthritis, which used to be routinely provided to patients, were being cut back. According to the report, doctors had to make special appeals to get these treatments approved for their patients. The cause of this rationing is said to be lack of funding as explained by local health bosses. This was substantiated by the British Medical Journal's report[894] that a special case system which was hitherto used to get approval for drugs or other treatment not readily available on the NHS, was now being used to get approval for the afore listed routine treatments.

The BBC report further outlined the increase in the number of requests for these treatments, which are meant to be routine, compared to requests made in 2013/14. By 2016, the request for these routine procedures through the special case system had risen by 47% and just a little over half of the requests were approved.[895]

The chief executive of NHS Clinical Commissioners was reported to have said that the NHS is doing its best, but cannot meet all the demands in the reality of limited resources, and her colleague alluded to "spiralling demand, competing priorities, and increasing financial pressure".[896] Unfortunately, while patients requiring hip and knee replacements may live in pain for longer, patients with cataracts stand the risk of losing their sight and become prone to "social isolation, depression, and fall-related injuries".[897]

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893 Triggle N, "NHS rationing leaves patients in pain" https://www.bbc.com/news/health-40485724 (Date of use 10 June 2019).

894 Mann N "Knee and hip surgery refusals: rationing policy will do more harm than good" 2018 *BMJ* 362.

895 Matthews-King A "NHS surgery rationing on the rise as thousands rejected for cataract surgery: investigation finds" https://www.independent.co.uk/news/health/nhs-cataract-surgery-operation-waiting-list-rationing-ccg-a8935641.html (Date of use: 10 June 2019).

896 https://www.independent.co.uk/news/health/nhs-cataract-surgery-operation-waiting-list-rationing-ccg-a8935641.html (Date of use: 10 June 2019).

897 Quotations by Helen Lee, of the Royal National Institute of Blind People https://www.bbc.com/news/health-40485724 (Date of use: 10 June 2019).

When related to patient's rights, rationing may be considered from the question whether a patient who is denied treatment due to rationing loses any of his or her fundamental human rights in the process. If the answer is negative, then rationing, in that case, may not be considered a breach of the patient's rights. However, where any of the patients' rights or human rights will be breached, then rationing in that instance should be suspended. Therefore, the analysis of the impact of rationing on patients' rights should be done on a case by case basis.[898]

In order to escape the implication of rationing and the stiff competition for limited, often free public health services, patients have taken to self-help in the form of seeking treatment from private healthcare facilities. Although it guarantees treatment, seeking medical care from private medical practitioners has its downturn. This is considered below.

5.8 Private healthcare and patients' rights in the United Kingdom

The UK also has a private healthcare sector. This sector is largely funded by medical insurances paid for by employers for healthcare provision to their employees. Additionally, patients may utilize the NHS for a first visit to a GP, but continue upon a referral, on a private arrangement. Some private sector practitioners also subcontract for the NHS, so that patients on NHS may receive healthcare from the private sector on the NHS bill. The CQC also monitors and inspects the private sector practitioners.

In an April 2018 report,[899] the CQC was quoted to have warned about the risks associated with the informal procedure of consultants taking their patients to private sector facilities, which they (the consultants) are not employees of. It opined that these facilities cannot address the failings of such consultants. Moreover, only a handful of private sector health facilities could handle emergencies. The CQC referred to Ian Paterson, a clinician who was convicted of multiple charges of wounding with intent.[900] His patients were treated in the

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898 *R v Cambridge Health Authority, ex parte B (a minor)* (1995) 25 BMLR 5, 17 (QB); *R v Cambridge Health Authority, ex parte B (a minor)* 1995 23 BMLR 1.

899 Lintern S 'Policy and regulation: CQC warns real danger for safety in private sector hospitals' https://www.hsj.co.uk/policy-and-regulation/cqc-warns-real-danger-for-safety-in-private-sector-hospitals/7022135.article (Date of use 8th March 2019).

900 https://www.bbc.com/news/uk-england-birmingham-43552926 (Date of use: 8th March 2019).

private sector. An assessment of how easily Ian was able to inflict wounds on his patients showed it was due to the gaps in the safety procedures and the informal practice associated with the private sector.

Engaging health services in the private sector reduces patients' waiting time. Waiting time on the NHS is 8 weeks for referral from a GP to a specialist, but that will not be the case with a private arrangement with the physician. Also, there will be no denial of treatment on any ground in the private sector, unlike the NHS where rationing and triage determine who gets attention first, and which services are free. Additionally, patients are at liberty to pick the best treatment they can afford, as opposed to the NHS managing its resources to recommend only affordable treatments to patients due to limited resources.[901]

Moreover, physicians are personally liable in the private sector, while in the NHS vicarious liability applies to the physician. The issue of vicarious liability may permit some incompetent physicians to hide behind the NHS, to avoid taking responsibility for their negligent actions, while a private physician needs to exercise additional care to ensure his licence is not revoked, nor his reputation damaged on account of one instance of negligence.

Conversely, the private sector may be driven by profit and even offer patients unnecessary treatments to impose higher fees on them and the private health facilities are not as well equipped as the NHS facilities. Their physicians' specialities may also not be as diverse as those of the NHS facilities, hence securing a well-rounded diagnosis or treatment plan may be impossible. Private physicians are not answerable to a system *per sé* and do not have one document listing their responsibilities. Patients who want to initiate an action against them, need to be aware of all regulatory[902] positions, the social and healthcare acts and the human rights act to have an accurate basis for any lawsuit. Evidently, a lawsuit against a hospital in the private sector will be more costly because patients will need the services of lawyers, while with the NHS, patients can directly lay complaints and personally escalate it as desired.

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901 *R v Cambridge Health Authority, Ex parte B* [1995] EWCA Civ 43.

902 General Medical Council.

5.9 Conclusion

Patients' rights in the UK have been introspectively observed in this chapter with the focus on the NHS Constitution. This chapter analysed the various rights which the Constitution provides for. They include the right to access health services, the right to quality of care and environment, the right to nationally approved treatments, drugs, and programs, the right to respect, consent and confidentiality, the right to informed choice, complaints and redress. The NHS Constitution is seen as a model document detailing the rights of the patient.

This chapter also highlighted some cases which have emphasized and shown the disposition of courts to uphold the rights of patients. Of significant mention, is the fact that some of the cases identify that the persons responsible for the protection of patients' rights may not be medical professionals or practitioners. They may include receptionists, telephone operators or other employees. A far as liability is concerned, there is no distinction between medical and non-medical personnel, and everyone who is linked to the health service provision of the patient, must be aware of the rights of the patient and protect them. The chapter also identified a significant similarity in patients' rights protection which the courts in England have promoted. A patient must have the right to make medical decisions even where the state is of a different opinion.[903] Courts must act as independent arbiters where healthcare practitioners attempt to subvert patients' will and the courts must enforce patients' best interests where it will not be against public policy.

This chapter also highlighted the role of the CQC which is an independent body monitoring the provision of healthcare services in England.[904] The need for a functional body which releases periodic reports and standard gauges for healthcare services is believed to keep the providers of health services on their toes to make the rights of the patient a priority. An important discussion on the rights of patients in the UK over the last decade is the privatization of health

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903 *Re T (Adult Refusal of Medical Treatment)* [1992] 4 All ER 649, 652-653 per Lord Donaldson who emphasized that as long as the patient had capacity, the patient had a right to choose or refuse medical treatment and this right is not limited to choices deemed as sensible, and the reasons do not have to be known, rational or even existent.

904 https://www.cqc.org.uk/news/stories/our-fundamental-standards (Date of use 27 August 2019).

services and how this influences patients' rights. While the privatization of healthcare might improve the rights of patients, the profit orientation of the private services might deprive several citizens of the right to access health services, as the cost of effective healthcare will be out of the reach of a larger number. The government is, however, showing some financial commitment to the NHS which might reduce the fear that only rich patients will have access to healthcare.

The NHS Constitution for the purpose of this research is presented as a model document for patients' rights protection. The seeming inevitable commercialization and privatization of some health services occasioned by the need for funding and the financial burden of maintaining the NHS suggest that neither the NHS nor the healthcare management systems of the other countries in the comparative analysis are going to attain the ideals of the NHS Constitution in upholding patients' rights.[905] This chapter concludes that the ideals of the NHS Constitution are the *Shangri-La* for healthcare and patients' rights, but its sustainability may be shaky due to the paucity of funding. In an earlier discussion on rights in this research, a need was identified for some rationing yardstick to determine "who gets what", where the health system cannot provide for all at the same time.

The UK health system is compared in the next chapter to the legal instruments in Nigeria and South Africa. The chapter also compares some of the decisions of courts in the different jurisdictions within the scope of healthcare. This chapter is utilized as a basis for the comparison of the role of some of the enforcement and regulatory agencies which are expected to protect the right of patients. It is at the comparative level that this research indicates that the CQC is required to tighten the noose if it is to regulate healthcare successfully in England. Its regulatory activities are, however, a guiding light for South Africa and Nigeria respectively.

905 Pollock *NHS plc The Privatization of Our Healthcare* 33.

CHAPTER 6: A COMPARATIVE ANALYSIS OF PATIENTS' RIGHTS IN NIGERIA, SOUTH AFRICA AND THE UNITED KINGDOM

6.1 Introduction

As discussed in previous chapters it is evident that the three countries within the scope of the research have rights protection mechanisms which enable the promotion of patients' rights, although each country has its own approach to rights in general. Also, as discussed in chapter two of this research, political rights,[906] which are traceable to natural[907] and legal rights,[908] have led to the evolution of political systems of administration. Having commenced discussion on rights in general and patients' rights in each country, I now harmonize thoughts comparatively in this chapter with a view to suggest areas of needed improvements in each country.

I commence the discussion with a comparative analysis of the legal framework in the target countries; then I discuss the effect of international laws on patients' rights; specifically, the African Charter as a nexus between healthcare rights in Nigeria and South Africa. I test the effectiveness of laws by examining case law and judicial precedents from each jurisdiction. This is a link to the third aim of this chapter which is to discuss enforcement mechanisms, agencies and schemes in place to guarantee the protection of patients' rights in the target countries. To satisfy this aim, I discuss healthcare financing and rationing; evaluate health insurance schemes in South Africa and the UK and how same can mitigate the problems in healthcare; discuss the litigation and compensation systems in practice to enforce patients' rights; examine the no fault compensation system in the UK and its contribution to reducing the cost of compensation; and finally, non-litigation approaches to remedy patients' rights infringement in South Africa and Nigeria.

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906 ICCPR UN General Assembly Resolution 2200A [XXI] December 16 1966.

907 Pangle T *The Spirit of Modern Republicanism* (University of Chicago Press Chicago 1990) 119.

908 Laski HJ "The rights of man" https://gutenberg.ca/ebooks/laski-rights/laski-rights-00-h.html (Date of use: 7 September 2019).

I conclude by highlighting the similarities and differences among patients' rights legislative and institutional mechanisms, in the target countries; this will indicate the current status of each country on the patients' rights ladder. This chapter emphasizes the argument that the UK NHS Constitution has an edge over other existing patients' rights regulations. The UK system, though flawed, is a relevant example for the other countries.

6.2 Universal rights and patients' rights: A comparative perspective

Every human being has rights.[909] These rights might even be extended to a deceased person.[910] The concept of rights is universal, although some countries are perceived to protect the rights of their citizens more than others. It is believed that many people all over the world understand the concept of rights, especially within the scope of natural rights, as earlier discussed in this research. This understanding is shaped by history and perspective. A country with a history of military rule, colonialism or slavery, will understand the right to freedom of movement differently from a country that has not experienced any subjugation. South Africa recently celebrated twenty-five years of democracy, while Nigeria, although a democratic state since 1960, just celebrated twenty years of democratic governance without military intervention. Therefore, both countries understand and better appreciate the need to preserve human rights.

Rights (especially human rights), as earlier defined, are universal to all humans; they denote entitlements enjoyed by persons.[911] These entitlements are attached to obligations, borne by others to ensure their fulfilment and the protection of their existence.[912] Rights are applicable to all cultural contexts.[913] As mentioned above, there are natural rights which are largely considered moral. There are also

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909 "Human rights and fundamental freedoms are the birth right of all human beings; their protection and promotion are the first responsibility of governments." Vienna Declaration and Programme of Action 1993. See UN OHCR https://www.ohchr.org/EN/ProfessionalInterest/Pages/Vienna.aspx (Date of use : 15 August 2019).

910 *Gloria Esegbona (on behalf of the estate of Christiana Esegbona, deceased) v King's College Hospital NHS Foundation Trust* [2019] EWHC 77 (QB).

911 Hoffman D and Rowe J *Human Rights in the UK: an introduction to the human rights act 1998* 4th ed (Pearson London 2013) 12-16.

912 Smith RKM *Textbook on International Human Rights 5th ed* (Oxford University Press Oxford 2012) 33.

913 Bell *Political Theory* 849. (first time?)

legal rights, which are codifications of the natural rights. Rights and the restriction on rights could be illustrated by an example: Mrs. A has a right to wave her hands; Mrs. A's right to wave her hands, however, ends where it becomes a slap to the face of Mrs. B. So, for a right to be accorded the weight it deserves, it ought not to deprive some, to endow others. All persons should have rights, and the state should protect these rights and ensure redress in cases of breach.

The rights under consideration in this research are patients' rights, which are deducible from the premise that rights are not suspended when one is a patient. Therefore, while some legal systems have patients' rights spelt out in distinct legal instruments, those that do not, deduce them from existing rights which have been provided for in their various laws. The direct or indirect legislation on patients' rights, along with the framework for rights, protect patients for all intents and purposes.[914] In South Africa and Nigeria, rights, which are also applicable to patients, are protected primarily by the countries' constitutions. Patients' rights are additionally protected specifically by some form of soft law, such as the Patients' Bill of Rights and the SA Charter. Both countries have a human rights commission charged with the task of ensuring that human rights are upheld, and remedies guaranteed when there are breaches. In the UK, the Human Rights Act of 1998 sets out the provisions for the protection of human rights by the courts.[915] Comparatively, the human rights records of Nigeria and South Africa are not up to the UK standards, as is deducible from the conclusions from chapters three, four and five of this research. Although the UK also has records of human rights violations, especially patients' rights violations,[916] these violations are minute when juxtaposed with the daily desecration of patients' rights of citizens in Nigeria and South Africa.

Before progressing to compare the protection of patients' rights, I will attempt to identify the similarities in the practices in each of the three target jurisdictions.

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914 Most of rights classified as patients' rights are connected to the existing first, second and third generation rights. See Davis *Human Rights Law* 11-12.

915 The Human Rights Act 1998 came into force in October 2000 enabling individuals enforce their rights.

916 See for example Shipman Inquiry Reports at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273226/5853.pdf (Date of use: 9 September 2019).

6.3 The similarities between the United Kingdom, Nigeria and South Africa: Colonialism, the Commonwealth, and a Common Law history

Nigeria was a colony of Great Britain from 1901 to 1960. It is a member of the Commonwealth of Nations, a political association of 53 member states that were former British Colonies. Nigeria joined the Commonwealth on 10th October 1960. While ruling the colonies, Britain had spread its historical judge-made-law, now called "case law" across its colonies. Until 1st January 1900,[917] British case law had authority in Nigeria as far as local jurisdictions and circumstances permitted.[918] Notably, South Africa is also a member of the Commonwealth; it joined the association in 1931 and although it left temporarily after 30 years, it re-joined in 1994.[919]

The Commonwealth was created in the 1900s to ease the decolonization of the British colonies. The organization created diplomatic ties between member nations. A bi-annual Commonwealth Heads of Government Meeting is held to share projects and the progress on the execution of certain undertakings. The secretariat of the Commonwealth sits in the UN as an observer. The 1971 Singapore Declaration stated the objectives of the Commonwealth to be, to support the UN's aim of world peace; to oppose all forms of colonial domination and racial oppression; to achieve the freest flow of international trade; and to achieve these through consultation, discussion, and cooperation.[920]

Nigeria's rights model is influenced primarily by English law, as a natural consequence of its former colonization by Great Britain.[921] The evolution of the Nigerian rights framework over time, is fashioned after the regional and international treaties it has ratified and domesticated. South Africa's rights model

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917 The Interpretation Act chapter 192 Laws of the Federation of Nigeria 1990 section 32(1).

918 Lokulo-Sodipe J, Akintola O and Adebamowo C "Legal basis for research ethics governance in Nigeria" https://elearning.trree.org/mod/page/view.php?Id=142 (Date of use: 19 February 2019).

919 http://www.commonwealthofnations.org/country/south_africa/ (Date of use: 7 September 2019).

920 Singapore Declaration of Commonwealth Principles 1971 (2004) Commonwealth Secretariat Communications and Public Affairs Division Marlborough House Pall Mall, London SW1Y 5HX United Kingdom.

921 Obilade AO *Nigerian Legal System* (Spectrum Law publishers Oyo 1979) 39.

is foundationally influenced by the Dutch[922] and the English Law;[923] it, however, developed along the lines of the international framework of human rights. The UK started out with a monarchical system and its rights model developed for the citizens as the need for their emancipation from certain authoritarian kings required.[924]

The impact of the common law history on Nigeria's health sector is seen firstly, in Nigeria's legislation on health and the application of these legislation by the judiciary. Decisions of the English courts up to the 1900s carry persuasive weight in the Nigerian courts and to this extent, were referred to in earlier health court cases; those earlier suits are precedents for the recent decisions. In *Medical and Dental Practitioners Disciplinary Tribunal v. Okonkwo,*[925] the court referred to *R v Akerele* (1941) 7 WACA 56. "WACA" refers to the West African Court of Appeal which served as the appellate court for the British colonies in time past. Reference was also made to *Sloan v General Medical Council* [1970] 2 All ER 686. Where ER refers to the All England Law Reports, a long-running series of law reports covering cases from the court system in England and Wales.

The Commonwealth once suspended Nigeria after the killing of Ken Saro Wiwa, an environmental activist, who had earlier been referred to in this thesis and on behalf of whom a case had been instituted at the African Human Rights court.[926] The suspension is noteworthy not because of a denial of the right to health or treatment but because actions of that nature justify the argument in this research – that a global and regional framework can bring solace to individuals when states are also answerable to regional and international bodies.[927]

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922 Bradfield G, Du Bois F and Wille G *Wille's principles of South African law* 9th ed (Juta Cape Town 2007).

923 Thomas PhJ, Van der Merwe C and Stoop BC *Historical foundations of South African private law* (LexisNexis South Africa 2016).

924 Pollock F *The history of English law before the time of Edward I* 2nd ed (Lawbook Exchange New Jersey1996) 6-18.

925 (SC 213/1999) [2001] 10 (02 March 2001).

926 http://thecommonwealth.org/history-of-the-commonwealth/nigeria-suspended-commonwealth (Date of use: 15 August 2019).

927 Nigeria's agricultural technical assistance programme was stopped when it was suspended from the Commonwealth. Nigeria was also excluded from Commonwealth events and meetings.

6.4 System of government and its influence on the medical sector

The system of government in a nation, in tandem with the prevailing economic policies, will influence the nation's approach to rights and their enforcement. A system of government refers to how power is shared and controlled between the various arms of government. In a presidential system, the legislature enacts the laws, the executive administers the law, while the judiciary metes out justice to the public. In a parliamentary system, the members of the executive are chosen from the parliament.

The Prime Minister in the UK is a member of the parliament and only *primus inter pares*.[928] Nigeria runs a three-tier system of federal, state, and local government, under a federal system of government; the federal and state levels each have their legislative houses. South Africa also runs a central and provincial system, where the provinces have their own legislative powers. The effect of the balance of power between the arms of government and the tiers of government in the three nations varies, as defined by their system of government. A major challenge in Nigeria and South Africa is that the central governments wield most of the power and control of resources, whereas a large proportion of their population is directly dependent on the local or provincial services, despite its constrained resources.

It should be noted that in both countries, healthcare is the mutual responsibility of federal, state, national, provincial and local government.[929] The national or federal government, depending on nomenclature in use, has the greater responsibility for citizens' healthcare.[930] The effect of the above, in the South African system, is that national audits and hospital reviews show some progress in some provinces and municipalities but regression in others.[931] This is caused by the politicized national approach to developing the health sector, so that political parties in power can claim victory over others, instead of ensuring evenly

928 https://www.merriam-webster.com/dictionary/primus%20inter%20pares (Date of use: 9 September 2019).
929 Constitution RSA schedule 4.
930 Carstens and Pearmain *Foundational Principles* 214. See also *Government of the Republic of South Africa v Grootboom* 2001(1) SA 46 para [66] 79.
931 http://www.samed.org.za/Filemanager/userfiles/Public%20Health%20Facilities%20audit% (Date of use: 8 September 2019).

spread healthcare development across the nation, especially to persons in rural communities. The UK does not have the same problem, though it has its own ethnic minorities, super group areas, county living, and industrial local areas. The UK has successfully provided standard healthcare across the board by ensuring that the various NHS Trusts are managed and monitored at the community level.[932]

Additionally, the economic policies of a nation are keys to administering healthcare. The heads of the various tiers of government draw up the budgets, allocate the resources and approve the budget for disbursement in each tenure of government.[933] The decision about what percentage goes to healthcare lies with the government; and the efficiency of the usage of the funds earmarked for healthcare depends on the financial culture of that nation. As it should be, healthcare is an economic and social right, which is anchored in the capacity of the nations, but the decision of governments on what percentage of the scarce funds goes to healthcare is subjective and often does not display the capacity of the government *per se*, as there is still a divergence of opinion on the status of socio-economic rights.[934]

Each of the three nations under consideration has internal challenges with prioritizing health in the national budget. The UK with its enviable standard of health practice is not left out. Rationing due to limited funds[935] (to be discussed below) has led to protests from the public. Capitalist systems produce health services which are relatively consumer-friendly but costly and unaffordable. This is the case in Nigeria and is gradually becoming the case in South Africa and the UK. Nigeria has a unique problem of corruption in the public system, such that, even if there is a clamour for more funds to be directed to the health sector in the budget, there is no guarantee that the funds will be utilized for its primary purpose,

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932 NHS England- Board paper https://www.england.nhs.uk/wp-content/uploads/2018/03/09-pb-29-03-2018-scene-setter-on-current-trends-health-inequalities.pdf (Date of use: 15 August 2019). See also Szczepura A 'Access to healthcare for ethnic minority populations' https://pmj.bmj.com/content/postgradmedj/81/953/141.full.pdf (Date of use: 15 August 2019).

933 See for example s 85 of the SA NHA.

934 Steiner HJ, Alston P and Goodman R *International human rights in context; Law, politics and morals* (Clarendon Press Michigan 1996) 280-282.

935 See Mason JK, McCall Smith RA and Laurie GT *Law and Medical Ethics* 6th ed (LexisNexis UK 2002`) 388-390 on health resources and dilemmas.

or that it will be effected at the optimal level.[936] For example, when funds are approved for the purchasing of equipment for cancer screening and the appeal for health financing has been successful, discarded machinery in other climes may be refurbished and imported to the cancer centres instead of new machines. These second-hand machines may not deliver optimally or may develop faults too soon. In such a case, the clamour becomes counter-productive, because the government can no longer be accused of failing to fund healthcare, since it has delivered machines. The government officials and contractors who have made the actual purchases have in fact, short-changed the system by surreptitiously bringing in sub-standard machinery. Sadly, because this financial corruption is a thread that weaves through the entire public system in Nigeria, the corrupt officers usually get away with no punishment to deter others and so the cycle continues.[937]

The argument of this research is that each country must align its system to be people and patient centred. A government system that is tailor-made should be adapted to include free primary healthcare services and relative insurance coverage for most citizens. Below is a brief description of the government systems run by the countries in the comparative analysis done in this study *vis-a-vis* the provision of medical care. Some connections are drawn from the system of government practised and patients' rights in their jurisdictions.

6.4.1 South Africa

The Republic of South Africa is a constitutional republic with national, provincial and local levels of government. The executive authority, at the national level, is vested in the President. The President is the head of state, government and of his cabinet. Legislative authority is held by the bicameral parliament and the president is elected by parliament for a fixed term. The president appoints members of his cabinet from the parliament. The ministers in the cabinet are

936 Obansa identifies pervasive corruption and sharing of unallocated budget funds as one of the major challenges of the health system which directly affects patients. See Obansa SAJ and Orimisan A "Healthcare financing in Nigeria: prospects and challenges" 2013 *Mediterranean Journal of Social Sciences* 224.

937 Oyekale AS "Assessment of primary healthcare facilities' service readiness in Nigeria" 2017 *BMC Health Services Research* 2-3.

answerable to parliament. There is also an independent judiciary at the national level.[938]

The country's healthcare is run concurrently by the public and the private sector.[939] Non-governmental organizations and faith-based organizations are also involved in the delivery of healthcare.[940] Montogomery[941] describes the South African health system as divided along socio-economic lines, stressing that public healthcare is relatively free for citizens, although fraught with numerous issues, leading to a preference for private healthcare which is primarily paid for through medical aid schemes. Citizens who can afford private healthcare are treated by private doctors or hospitals, which appear to be more conscious of patients' rights compared to public facilities. Private healthcare patients bear the expensive cost of medical aid contributions for their benefits. These include shorter waiting times, more qualified staff, better infrastructure and care.[942] The advantage of the public health system, which most patients use, is government funding, free care and provision of pharmaceuticals. The greatest disadvantage of the public health system is that the patient is at the mercy of the health practitioner and there are myriad problems such as underfunding, lack of resources, understaffing, poor staff welfare, long hospital waiting times, and poor health practices.[943]

South Africa's public sector has primary, secondary and tertiary hospital levels. Primary level hospitals offer basic healthcare, internal medicine, general practice, and surgery. Patients may be referred to secondary healthcare facilities when the case cannot be handled at the primary level. Secondary care infers the need for some specialized professional care. The primary and secondary level hospitals

938 https://www.gov.za/about-government/government-system/structure-and-functions-south-african-government (Date of use: 17 February 2019).

939 Ataguba JEO and Akazili J "Healthcare financing in South Africa: moving towards universal coverage" 2010 *Continuing Medical Education* 74-77.

940 Carstens and Pearmain *Foundational Principles* 229.

941 Montogomery *Private vs. Public healthcare in South Africa* 3.

942 Maseko and Harris 2018 *SA Journal of Occupational Therapy* 23.

943 Montogomery *Private vs. Public healthcare in South Africa* 3. She identified long waiting times, a lack of glove usage, a poor hygiene culture with bed linens not being washed, hand washing as an optional but encouraged activity, multiple use of bed linens and the re-using of medical instruments.

may refer a patient to tertiary care for specialized equipment, technical expertise, and conditions which may require complex procedures.

There are also some patients who use and prefer traditional systems of healthcare. The majority of South Africans trust traditional healers more than the medical practitioners.[944] A major difference between the South African system and the other two countries in this comparison is the recognition of the traditional health practices and practitioners.[945] When fully implemented, the Traditional Health Practitioners Act will protect users of traditional health practices and enhance rights enforcement for a large number of people. Notably, this will mean that the poor and the uneducated in rural areas will have their rights as patients protected through measures legislated by the state.[946]

South Africa is currently executing the National Health Insurance (hereafter "NHI") scheme which is aimed at eradicating barriers to healthcare access and bringing equity for all citizens and patients.[947] The scheme is expected to be carried out over an extended period as some of the set targets are yet to be met. The first phase of the NHI plan is complete, while the second phase is ongoing. The last phase will be the establishment of the NHI bodies, structures and commissions which are expected to improve basic healthcare for all South Africans.[948] Although critics have suggested that funding will be a major limitation for the scheme, the veracity or otherwise of their claims will be known as time unfolds.

6.4.2 Nigeria

Nigeria, a federal republic, has three tiers of government, namely federal, state and local governments. The legislative arm is bicameral at the federal level and unicameral at the state level. The three arms of government are expected to

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944 Montogomery *Private vs. Public healthcare in South Africa* 13.

945 Traditional Health Practitioners Act 22 of 2007.

946 In America, a herbalist was sentenced to jail for giving herbs to a 13-year-old and advising him not to use insulin. Nedelman M "Herbalist sentenced after death of diabetic boy advised not to use insulin" https://edition.cnn.com/2019/02/27/health/herbalist-diabetes-death-sentencing/ (Date of use: 16 August 2019).

947 Department of Health, Republic of South Africa Annual Report 2017/18 1. Report can be accessed at https://www.gov.za/sites/default/files/gcis_document/201810/doh-annual-report-2018.pdf (Date of use: 9 August 2019).

948 Department of Health, Republic of South Africa Annual Report 2017/18 1.

serve as checks and balances on each other. The Nigerian Constitution is the law from which all other statutes derive their validity.[949] Nigeria's economy is a mixed economy.[950]

The public healthcare sector in Nigeria is classed into three tiers: primary, secondary and tertiary. Each is run by the local, state, and federal government respectively. While the federal medical centres and teaching hospitals are administered by the federal Ministry of Health, the state general hospitals are run by the state and the primary healthcare centres are run by the local government authorities.[951] All these public health facilities are adequately spread across Nigeria**.** Unfortunately, they are usually unequipped or ill-equipped,[952] or equipment is mostly obsolete, and the facilities are understaffed. The staff are underpaid and embark on incessant strikes.[953] Health workers are offered incentives to work in rural areas, and the resultant effect is that these areas draw fresh graduates with no experience. Nonetheless, the NHIS is primarily enjoyable by employed persons who contribute 5% of their salaries, while the employer contributes 10% to the scheme. A contributing employee will, under the NHIS, receive health coverage for one spouse and four biological children.[954] In a nation like Nigeria where traditional and Islamic marriage rites permit more than one wife,[955] this scheme is inadequate. The NHIS also makes provision for random persons who pay a premium on it, to pay only 10% of their hospital bills at point

949 CFRN 1999 (as amended).

950 The Nigerian economy has a blend of public and private enterprises.

951 Akplagah W "Global heath: health systems in Nigeria" https://www.slideshare.net/wakplagah/health-systems-in-nigeria (Date of use: 18 August 2019).

952 For example, the tragic case of a medical doctor who was the head of internal medicine who died as an asthmatic patient in a hospital because there was no oxygen. If doctors who can usually pull all the strings are at the mercy of the system, the ordinary patient faces an even more daunting task. Nsofor I and Adejo P "Gasping for air: doctor's death exposes inherent risks of Nigerian public hospitals" https://nigeriahealthwatch.com/gasping-for-air-doctors-death-exposes-inherent-risks-of-nigerian-public-hospitals/#.XVbspOhKjIU (Date of use: 16 August 2019).

953 Obansa SAJ and Orimisan A "Healthcare financing in Nigeria: prospects and challenges" https://www.researchgate.net/publication/283609489_Health_care_financing_in_Nigeria_Prospects_and_challenges (Date of use: 16 August 2019).

954 https://www.slideshare.net/wakplagah/health-systems-in-nigeria (Date of use: 18 August 2019).

955 Nwauzi L "The rules of marriage in customary law" in *General principles of Nigerian customary law* (Nwauzi Akolokwu 2019) 79 https://www.researchgate.net/publication/339687110_THE_RULES_OF_MARRIAGES_UNDER_CUSTOMARY_LAW (Date of use 11 May 2020).

of treatment. That notwithstanding, the obsolete equipment, understaffing, poor quality of facilities and the inability to have a health provider of choice, render patients minimally satisfied with public health providers.[956] People prefer to self-medicate, consult "quacks" or drug stores, or to go to private hospitals and be forced to pay very high amounts for poorly regulated services. This has led to massive medical tourism from Nigeria; in fact, the current president is notorious for taking medical leave for hospital appointments in other countries.[957] The fallout of this is that patients' rights are not being prioritized by the system. Various strikes and protests have been staged to bring the governments attention to the situation, resulting in empty promises of action, injection of some funds into the healthcare system and commissioning non-functional bogus health service provision centres.[958] Unfortunately, the public officers who disburse the funds divert it through the purchasing of moribund machinery with exorbitant invoicing or outright theft. This directly affects the patient and the health practitioner's capacity to protect the patient. Although there are general laws to protect patients as humans in Nigeria, even the implementation and enforcement of those is very weak.

6.4.3 United Kingdom

The UK is a constitutional monarchy with the queen being a ceremonial head, while all political decisions are taken by the parliament.[959] The parliament promulgates various laws while the judiciary interprets these in precedents. There are three branches of government, namely: the executive, the judiciary and the legislature. The executive and legislature are not clearly separated. The High Court judges are appointed by the queen, on the advice of the Lord Chancellor. The Lord Chancellor is a senior member of the cabinet. The Prime Minister must be a member of the House of Commons, that is, the lower house of Parliament.[960] The UK government is therefore a unit with various tasks assigned to members

956 https://www.nhis.gov.ng/formal-sector-social-health-insurance-programme-fsship-/ (Date of use: 15 August 2019).

957 https://www.bbc.com/news/business-36468154 (Date of use: 18 August 2019).

958 Adeloye D *et al* "Health workforce and governance: the crisis in Nigeria" 2017 Human Resources for Health 32 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5427605/ (Date of use 11 May 2020).

959 https://guides.lib.umich.edu/unitedkingdom (Date of use: 18 February 2019).

960 Taucar CE *The British system of government and its historical development* (McGill-Queen's University Press Montreal 2014) 4-7, 203-204.

of the same unit, unlike the case in Nigeria where the National Judicial Commission recommends the appointment of judges, while the president and legislative officers are elected directly into office by the electorate composed of all Nigerians who have attained the age of majority and are registered to vote.

With the system described above, the likelihood of a disparity between bills from the parliament and the inclinations of the judiciary and executive is slim. It is deducible that any bill that evolves into an Act will have a wide acceptance from all the arms of government. This helps with the implementation of policies, regulations, and statutes. This system may be partially responsible for the success of the UK healthcare system. It might also explain why changes to the healthcare model generate public outcries without formal governmental efforts to reverse them, through checks and balances. To explain the synergy further, the parliament is responsible for the allocation of funds to the NHS while the Secretary of Health is responsible to government for the performance of the NHS.[961] If there is a public protest against a step taken by the department of health and social care, the minister, who has a mere oversight function, will revert to the Prime Minister who will in turn, wait on the Parliament to approve any changes to be made. The likelihood of a change being recommended or approved easily is slim because all the arms of government need consensus on the different public services offered.

According to Herring, the NHS is rightly described as "Britain's best loved institution".[962] Gordon Brown, a former British prime minister, was also quoted by Herring to have stated as follows: "the NHS is not just a great institution but a unique and very British expression of an ideal that healthcare is not a privilege to be purchased but a moral right secured for all".[963] He further states that the NHS is a political tool in the hands of politicians during campaigns, and always appears as a discussion topic during electioneering. This shows the impact that governments can have on health and by extension on the patients' rights of citizens. Subsequent governments, including the most recent of Prime Minister

961 Herring J *Medical law and ethics* 7th ed (Routledge London 2017) 43-46.
962 Herring *Medical law and ethics* 40.
963 Herring *Medical law and ethics* 40.

Johnson, have made significant decisions to show their support for the NHS and health system.[964]

6.5 A comparative analysis of the legal framework in Nigeria, South Africa and the United Kingdom

The legal framework for patients' rights as derivable from human rights in the UK may be traced through the 1215 Magna Carta, the 1679 Habeas Corpus Act, the 1689 Bill of Rights to the 1948 UDHR and the 1950 European Convention on Human Rights. These legal documents contain provisions for all members of the society and set the background for the specialized[965] Acts of Parliament or other international conventions currently in force.[966]

In South Africa, the legal framework for patients' rights as inferred from human rights has been built on the 1948 UDHR, the 1955 Freedom Charter, and the 1994 South African Bill of Rights.[967] The Bill of Rights imposes a duty on the South African government to respect the rights and dignity of all members of the South African society.

The Nigerian legal framework for human rights was set up post-independence by the 1960 and 1963 constitutions. Subsequent versions of the Nigerian Constitution expanded on human rights hence, the current Constitution has a

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964 Savage M "Boris Johnson promises 1.8bn pounds to boost the NHS" https://www.theguardian.com/society/2019/aug/03/boris-johnson-promises-one-point-eight-billion-pounds-for-nhs (Date of use: 15 August 2019). Reactions have followed this report to suggest that the funds are not as they seem and that the promise of the prime minister to improve twenty hospitals cannot be fulfilled with this amount as it is insufficient. See also Gainsbury S "Boris Johnson's 1.8bn pounds for the NHS isn't what it seems – just ask the trust" https://www.theguardian.com/commentisfree/2019/aug/05/boris-johnson-nhs-trusts (Date of use: 15 August 2019)

965 1965: Race Relations Act; 1965: International Convention on the Elimination of All Forms of Racial Discrimination; 1966: UK signs up to the European Court of Human Rights; 1975: Sex Discrimination Act; 1976: Race Relations Act; 1976: International Covenant on Economic, Social and Cultural Rights (ICESCR); 1979: Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); 1984: UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; 1989: UN Convention on the Rights of the Child; 1995: Disability Discrimination Act; 1998: Human Rights Act; 2006: Universal Periodic Review; 2008: UN Convention on the Rights of Persons with Disabilities (UNCRPD); 2010: the Equality Act.

966 https://www.equalityhumanrights.com/en/what-are-human-rights/history-human-rights-britain (Date of use: 19 February 2019).

967 https://www.sahistory.org.za/article/south-african-constitution-bill-rights (Date of use: 19 February 2019).

chapter dedicated to human rights. The Nigerian Constitution is the primary source of human rights and the other statutes or regulations derive their validity from the Constitution. International laws must be domesticated in line with the Nigerian Constitution to be binding. The institutional mechanisms set up to enforce human rights in Nigeria are the NHRC, the Public Complaints Commission, and the Federal Competition and Consumer Protection Council.
A combined reading of chapters three, four and five above would reveal that of the three jurisdictions, Nigeria seems to have the weakest legislative protection for patients. The reason for this assertion is that Nigeria is the only one of the three, which lacks a single legislation which is patient-focused, specifically catering to patients' rights. South Africa has the SA Charter; the UK has the NHS Constitution; while the closest body of rules Nigeria currently has to the specific mention of patients' rights is the Code of Medical Ethics (hereafter "CME"). The Patients' Bill of Rights has been in operation for over a year now, and there is still no evidence of its effect in enforcing patients' rights in Nigeria. .

Asides the fact that the CME lacks as much force as laws enacted by the legislature, a perusal of its provisions as outlined in chapter three above shows that it is practitioner-centred as opposed to being patient-centred; so, rather than stating what the patient's rights are, the CME states instead, the practitioner's duties to the patient. Another issue is that if the CME protects the patients at all, it protects them from practitioners only, how about health facilities, administrative workers in healthcare facilities and the government? Another point worthy of note is that South Africa has gone a step further to acknowledge the existence of traditional medical practice by promulgating the THPA (discussed in chapter four above). Nigeria on the other hand, lacks any such acknowledgment or consideration and this becomes disturbing when one considers that traditional medical practice is arguably just as rampantly practiced in Nigeria as it is in South Africa. What regulates these traditional health facilities? What protects patients of traditional medicine? The answer to both questions is, "nothing".

In all three countries, the professional disciplinary bodies have legal backing to discipline erring practitioners and the decisions by these bodies can be appealed against. The punishments that these bodies can endorse include a warning;

suspension; and erasure of a practitioner's name from the register of practitioners. It is, however, noteworthy that while erasure can be reviewed in the UK, it cannot be reviewed in Nigeria. There is no mid-range punishment in Nigeria. The rules state that there should either be a punishment or warning, six months suspension or erasure. This handicaps the disciplinary body, as it is not empowered to make decisions based on the offence spectrum. In addition, the UK has interim suspensions by the GMC which can be declared pending the determination of a case. This also exists in the HPCSA decisions in South Africa and can be a way of protecting the public. The HPCSA also has suspended sentences, where the good behaviour of a health practitioner can cancel an earlier punishment.[968]

With the current parliamentary system in the UK, laws are made on an as-needed-basis. Each law, specific to a public issue, is resolved by an Act of Parliament.[969] This is unlike the Nigerian and the South African approach with the rights captured expressly in their constitutions.

6.6 Effect of international laws on patients' rights

International law is reflected in treaties and other documents as ratified and acknowledged by international or regional unions. However, there is a requirement to domesticate these international instruments for the provisions to be binding. Ratifying an international instrument places an obligation on the government of the nation to conform to the standards set by the instruments ratified.

The WHO oversees international public health. South Africa, the UK and Nigeria are members of the WHO. The International Health Regulations (hereafter "IHR")[970] 2005, as set out by the WHO, binds all member countries for the protection of persons against the international spread of diseases. Article 2 of the IHR spells out its objectives as to curb, prevent and provide a public health response to the international spread of diseases. An example of this in action was

968 HPCSA Decision May 2018 Dr ARC Essay MP0355534/716/2009.
969 Slapper G and David K *The English Legal System* 17th ed (Routledge London 2016) 18.
970 https://www.afro.who.int/sites/default/files/2017-06/international_health_regulations_2005.pdf (Date of use: 3 March 2019).

the 2014 case of Ebola in Nigeria. A Liberian arrived in Nigeria infected with the Ebola virus. The first physician who attended to him died having contracted the disease, but the spread was curbed due to the rapid implementation[971] of an existing NCDC[972] plan, which deployed a Public Health Emergency Operations Centre (hereafter "EOC"). The Information Management System (hereafter "IMS") structure was based on the WHO's guidelines. The EOC had previously been deployed to resolve a lead poisoning outbreak in 2010. This EOC/IMS structure was used to track all contacts of the initial host of the Ebola disease and to confine them for treatment.[973]

There is presently no single international instrument which provides for the rights of patients. At best, there exist general human rights instruments like the UDHR, the ICESCR, amongst others, as well as regional instruments like the African Charter on Human and People's Rights. The European Charter of Patients' Rights is commendable; not only does it provide specifically for the rights of patients; it is binding and legally enforceable on all signatory states who are members of the European Union.

Some of the challenges that patients' rights in international law face, include the ratification and domestication of international instruments, enforcement of international law, and modus operandi of regional and international courts. This thesis suggests that the UN through its existing practice and judicial organ, the ICJ, can impose economic sanctions, grant judicial orders and ensure that member states commit to the protection of the rights of patients.

6.7 The African Charter as nexus between healthcare rights in Nigeria and South Africa

The African Charter on Human and People's Rights[974] is an international law spanning African countries that are signatories. It is a regional human rights

971 https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a5.htm (Date of use: 3 March 2019).
972 National Centre for Disease Control.
973 https://www.who.int/csr/disease/ebola/ebola-6-months/nigeria-senegal/en/ (Date of use: 3 March 2019).
974 https://au.int/sites/default/files/treaties/36390-treaty-0011_-_african_charter_on_human_and_peoples_rights_e.pdf (Date of use: 15 Aug 2019).

instrument that protects the human rights of a person within Africa.[975] Article 16(1) of the Charter provides that every individual has the right to attain the best state of physical and mental health, amongst others. Article 16(2) enjoins state parties to take all necessary measures to protect the health of their citizens and so ensure that they receive medical attention when ill. The African Court on Human and People's Rights works along with the African Commission on Human and People's Rights to protect human and people's rights in Africa despite their physical locations.[976] Nigeria and South Africa are parties to this Charter, but its articles are actionable to the extent of its domestication only. Nigeria and South Africa have ratified the protocol but have not made a declaration regarding the competence of the court to hear individuals and NGOs on matters arising from the Charter.[977]

In Nigeria, chapter IV of the Nigerian Constitution sets out the human rights provisions. The Nigerian Constitution stipulates that other legislations within the country are valid to the extent of their consistency with the Constitution. Section 34(1)(a) provides against inhuman and degrading treatment and section 35 provides for liberty. These are factors that contribute to the health and overall wellbeing of a person. However, the provision on health itself is in section 17(3)(d) that is in a non-justiciable portion of the Constitution. This limits the accountability of the Nigerian government on issues pertaining to healthcare within its borders despite the provisions of the Charter.

In South Africa, the Constitution RSA sets out the applicable human rights in chapter 2. The Constitutional Courts interpret these provisions. Section 27(1) of the Constitution RSA provides that everyone has the right to have access to healthcare services. In practice, it means that basic primary healthcare is offered

975 https://au.int/sites/default/files/treaties/36390-treaty-0011_-_african_charter_on_human_and_peoples_rights_e.pdf (Date of use: 15 August 2019). See also http://www.african-court.org/en/ (Date of use: 15 Aug 2019).

976 The court is established by Article 1 of the Protocol to the African Charter on the establishment of an African Court on Human and Peoples' Rights. This protocol was adopted on the 10th June 1998 by member states of the then Organization of African Unity (OAU) now (AU). The court delivered its first judgement in the year 2009. See http://www.african-court.org/en/ (Date of use: 15 August 2019).

977 http://www.african-court.org/en/ (Date of use: 15 Aug 2019).

for free by the state. There are however constant complaints of underfunding and poor management of facilities.

Nigeria and South Africa have a history of using state apparatus to deny some citizens like Ken Saro Wiwa[978] and Steve Biko,[979] among others, their right to health. It is worthy of note that despite the provisions of the African Charter and these countries being signatories, these persons among many were denied their right to health in detention and incarceration.

It can be deduced from the above that while the African Charter clearly provides a standard of healthcare provision which all state parties should strive to attain, Nigeria and South Africa are not fully implementing this provision. Given the resilient nature of Africans, we may rest this matter on "half a loaf of bread is better than none". Compared with the resources sustaining the models of the public provision of healthcare in developed countries, these African countries should be able to perform as well as the developed countries, given that they are equally financially buoyant. The UK is the example being laid out in this research for these two African countries to emulate.

6.8 Judicial precedents on patients' rights: Case laws and decision making in Nigeria, South Africa and the United Kingdom

Laws and procedures are the foundation for litigation. Case law is based on the doctrine of *stare decisis.* This refers to the authority which judicial decisions have in the interpretation of legal provisions. It is the principle that once a question has been answered by the courts, it must elicit the same response each time it is asked in future[980] although the instant case will have to be like the preceding case.

In Nigeria, the authority of a case law depends on the court from which it emanates. There is a hierarchy of court systems. While a Supreme Court's (being the highest court of record) decision binds all courts in Nigeria, a Court of Appeal

978 *International Pen and others. on behalf of Saro Wiwa v Nigeria* AHRLR 212.

979 Moodley K and King S "History of medicine dual loyalties, human rights violations, and physician complicity in Apartheid South Africa" 2015 *American Medical Association Journal of Ethics* 966-968.

980 https://www.britannica.com/topic/stare-decisis (Date of use: 6 August 2019).

decision only binds the lower courts, but not the Supreme Court. The decisions of High Courts are persuasive, one to the other, but not binding on the other high courts.

In South Africa, the Constitutional Court is the highest court in the country and binds all other courts. A decision of the Supreme Court of Appeal will be binding on all High Courts and lower courts. Similarly, decisions by High Courts will be binding on the lower courts. There are several High Courts in nearly all the nine provinces. Magistrates' Courts are in different magisterial districts. The decisions of the High Courts are persuasive but not binding except on lower courts. The courts in South Africa do not make laws but adjudicate principles of legislation.

In the UK, the courts may create a law where no legislation exists on the matter at hand. Thus, while judicial precedents in South Africa and Nigeria are a court's interpretation of existing laws, the UK courts can create laws.

The patients' right to consent to treatment was debated in the British case of *St. George's Healthcare NHS Trust v. S.*[981] The Court of Appeal held that S's detention in a medical facility upon a High Court order was erroneous. The High Court was misled to understand she was diagnosed as mentally unstable. Her transfer to a mental health facility was thus unlawful.

The right to consent before treatment is started is also extremely important in case law in Nigeria[982] and in South Africa.[983] In the Nigerian case of *Danjuma Tanko v Dr. Rom Okekearu,*[984] the appellant was aggrieved because his finger had been cut off by a doctor as part of his treatment without his consent. The Supreme Court Judge stated that "the amputation of the plaintiff's finger was done intentionally and without the consent of the plaintiff or his guardian". After considering the evidence and arguments presented at the trial and appeal courts, the Supreme Court Judge[985] stated that for consent to be valid and real, there is an obligation upon the doctor to explain to the patient in detail the treatment he

981 [1998] 3 All ER 673, (1998) 2 CHRLD 323.
982 *Danjuma Tanko v Dr. Rom Okekearu* (2002) 9-11 SCNJ 101 or (2002) 9 ilaw/SC.73/1998.
983 *Castell v De Greef* [1994] 4 All SA 63 (C).
984 (2002) 9-11 SCNJ 101 or (2002) 9 ilaw/SC.73/1998.
985 http://ilaw.com.ng/dr-rom-okekearu-v-danjuma-tanko/ (Date of use: 24 February 2019).

proposes to administer. The learned judge cited authorities in tort[986] which opined that the patient must be given adequate details about the intended medical procedure to allow room for informed consent to the procedure.[987] However, in the South African Case of *Castell v De Greeff,*[988] the theory of therapeutic privilege[989] partly absolved the physician of flouting the requirement of informed consent.

Patient confidentiality was discussed in the English case of *W v Egdell.*[990] The appellant, a prisoner in a secure medical facility, sued an independent medical practitioner who assessed him and sent his medical report to the hospital's doctor and the Public Office considering his (the appellant's) release to a non-medical facility. The court held that the breach of confidentiality was in the interest of the public, but that such risk posed must be "real, immediate and serious"[991] for it to be permitted to breach the patient's right to confidentiality. Additionally, some statutes in the UK require the disclosure of confidential information even if it falls within the ambit of a breach of the right to confidentiality.[992]

In the Nigerian case of Prof. Zakari Aliyu, who was the Chief Medical Director of Taraba State, he had divulged the details of the illness of the then Governor of Taraba, Alhaji Danbaba Suntai, to the Taraba State House of Assembly after the Governor survived a plane crash. The Nigerian Medical and Dental Council summoned him to respond to allegations of the breach of doctor-patient

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986 Clerk, Lindsell and Dugdale *Clerk & Lindsell on Torts* 61.

987 Clerk, Lindsell and Dugdale *Clerk & Lindsell on Torts* 62.

988 [1994] 4 All SA 63 (C).

989 A therapeutic privilege (or therapeutic exception) refers to an uncommon situation whereby a physician may be excused from revealing information to a patient when disclosing it would pose a serious psychological threat, so serious a threat as to be medically contraindicated https://medical-dictionary.thefreedictionary.com/therapeutic+privilege (Date of use: 24 February 2019).

990 [1990] 1 ALL ER 835.

991 http://www.ukcen.net/ethical_issues/confidentiality/legal_considerations (Date of use: 24 February 2019).

992 Police and Criminal Evidence Act 1984; Public Health (Control of Disease) Act 1984 and Public Health (Infectious Diseases) Regulations 1988; Abortion Regulations 1991; Births and Deaths Registration Act 1953; Road Traffic Act 1988; Human Fertilisation and Embryology Act 1990; NHS (Venereal Diseases) Regulations 1974; Children Act 1989 and Prevention of Terrorism (Temporary Provisions) Act 2000.

confidentiality. Unfortunately, he didn't honour the summons of the Council on this matter.[993]

In the South African case of *Tshabalala-Msimang and Another v Makhanya and others*,[994] a case that borders on the right to privacy and confidentiality, the applicant was a member of the government of South Africa and the respondents were editor, journalist and owner of the Sunday Times newspaper. The first applicant in this case, was the patient was treated by Medi clinic, the second applicant. The newspaper Sunday Times published a sensational article with the title "Manto's Hospital Booze Binge" which chronicled the patients' hospital stay, and the applicant contended that the article was in breach of the patients' right to confidentiality and her right to privacy and dignity. The newspaper also had her medical records, which had been illegally obtained from the hospital. Although the newspaper attempted a defense based on the fact that she was a public figure and it was done in public interest, the court emphasised the Constitutional right to privacy, dignity and confidentiality citing sections 2, 14, 15 and 17 of the National Health Act and Section 14 of the Constitution RSA. The court held that there was a breach and that the recognition and protection of dignity is the "touch stone of the new political order and fundamental to the new constitution".

A patient's right to life was upheld in the English case of *R v. Cox*[995] where a medical doctor administered potassium chloride to a patient and the patient died within minutes. The patient was a 70-year-old woman who was undergoing treatment for an incurable and increasingly distressing form of arthritis. She had extracted a promise from the doctor that he would not let her suffer. The drug administered had nothing to do with the patient's illness. The doctor was convicted of attempted murder. The principle against mercy killing that a doctor ought not to treat patients with medication to cause death was hereby upheld. Assisted suicide is a criminal offence in the UK,[996] and a felony which carries the punishment of life imprisonment in Nigeria.[997] In South Africa the Supreme Court

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993 http://www.informationng.com/2014/03/suntai-personal-physician-faces-disciplinary-tribunal-for-divulging-govs-health-status-to-press.html (Date of use: 18 August 2019).

994 *Tshabalala-Msimang and Another v Makhanya and others (18656/07 [2007] ZAGPHC 161*

995 [1992] 12 BMLR 38.

996 Suicide Act 1961, section 2.

997 Criminal Code Act Chapter 77 Laws of the Federation of Nigeria 1990, section 326.

of Appeal ruled against assisted suicide in the case of *Stransham-Ford.*[998] In the *Stransham-Ford's* case, the High Court had granted the terminally ill patient the right to die by being assisted. This was to preserve the patient's dignity. The state appealed against the judgment and the Supreme Court of Appeal upheld it with the reasoning that parliament should make laws and until there is a new law, the right to life forbids assisted suicide.[999] A patients' right to life was protected in the Nigerian case of *Akintade v MDPT* where the doctor was suspended by the Medical and Dental Practitioners Tribunal for infamous conduct in a professional respect. The court held that the doctor caused the death of a patient, having failed to attend to the patient promptly. Furthermore, he was incompetent in the assessment and diagnosis of the patient in addition to making grave treatment and operative errors.

It is evident from the above cases that patients' rights have been upheld by the courts in all three jurisdictions under consideration. It is however believed that the limitation on courts in Nigeria and South Africa, precluding them from making laws sets the systems at a disadvantage compared to the UK where the courts are able to make laws in novel cases before them where no laws exist.[1000] It is also evident that international law, instruments and regulations have no jurisdiction in South Africa and Nigeria, unless and until same are domesticated, adopted and absorbed into the national laws. It is pertinent to highlight this because these two limitations of the African countries are great advantages for the UK healthcare system which should be duplicated in Nigeria and South Africa to experience and ensure growth.

6.9 Patients' Rights: Enforcement mechanisms and agencies

The enforcement of patients' rights is made possible through some systems and agencies of government, different from the instrumentality of the courts and human rights tribunals peculiar to each of the countries considered above, the countries in this research, have institutions in place to help enforce patients'

998 *Minister of Justice and Correctional Services v Estate Stransham-Ford* (531/2015) 2016 ZASCA 197.

999 https://www.medicalbrief.co.za/archives/sas-terminally-ill-lose-right-die/ (Date of use: 23 February 2019).

1000 This form of judicial activism can be seen in the case of *Airedale NHS Trust v Bland* [1993] A.C. 789.

rights. These agencies will be considered below, with a view to determine the force of law they possess to correct infringements on the rights of patients, as well as to determine their effectiveness and relevance over the years. The discussion on these agencies and the mechanisms of enforcement of patients' rights are segmented and discussed by countries, beginning with South Africa.

6.9.1 South African Human Rights Commission (hereafter "SAHRC")

The SAHRC was founded in 1995.[1001] The duties of the SAHRC include the dissemination of human rights awareness, investigations of human rights issues, and prosecution of human rights suits in courts.[1002] It monitors and seeks redress for all breaches of human rights reported to it and may also self-initiate prosecution. It was founded to ensure the implementation of constitutional democracy. Although there are cases of human rights infringements which the commission has involved itself with, it has only intervened in a few cases of patients' rights infringement. An example of such cases is the *Life Esidimeni* case, a visit to the Mamelodi Hospital[1003] and a visit to a hospital in Limpopo where rotten food was found.[1004] The few cases on record where it has intervened are a replica of the situation in many health facilities in South Africa. The SAHRC also engages Parliament on human rights related issues through its parliamentary liaison and legislation monitoring programme and has been said to have influenced the Choice on Termination of Pregnancy Act. It also monitors compliance with South Africa's international human rights treaties.[1005]

However, the SAHRC faces noticeable challenges which undermine its effectiveness. Firstly, the SAHRC is concerned with the protection of all human rights in South Africa, not just patient's rights; it's mandate is therefore too broad, heightening its constraints to deliver effectively. Likewise, the SAHRC is under-funded and under-staffed for the magnitude of tasks reposed on it. The SAHRC

1001 Human Rights Commission Act 54 of 1994.

1002 Human Rights Commission Act 54 of 1994, section 7(1).

1003 https://www.enca.com/news/shrc-probe-mamelodi-hospital-after-alleged-abuse (Date of use: 7 September 2019).

1004 Mojela M "SAHRC finds rotting food in Limpopo hospital" https://health-e.org.za/2019/07/26/sahrc-finds-rotting-food-in-limpopo-hospital/ (Date of use: 8 September 2019).

1005 Beredugo AJ *The role and effectiveness of National Human Rights Commissions in advancing domestic implementation of socio-economic rights in Commonwealth Africa* (LLD thesis, University of Pretoria, 2014) 265-266.

also has restricted powers of implementation of the provisions of the constitution on human rights. Although it has the power to bring a proceeding before a court or the tribunal, its recommendations to the executive and parliament to redress human right violations are not binding or legally enforceable. All these culminate to further hamper the effectiveness of the SAHRC.[1006]

6.9.2 Health Professions Council of South Africa

The vision of the HPCSA is to enhance the quality of health by regulating the various professions registered with it through the enforcement of standards set by the HPSCA to ensure ongoing professional competence and monitor conformity with the standards.[1007] It was established by the Health Professions Act. The Act mandates all persons that practice within the scope of the professions regulated by HPCSA to be registered or face criminal prosecution.[1008] This institution maintains a register of health practitioners, ensures qualifying academic criteria are met and maintained, and carries out corrective actions where registered professionals run afoul of its standards.[1009]

The HPCSA has published disciplinary decisions[1010] of the council where practitioners have been alleged to have infringed on the rights of patients. These can be from exposing patients to harm,[1011] failing to follow up on blood results, to inappropriate antenatal care.[1012] Other cases have ranged from misdiagnosis, inadequate operative inquiry,[1013] infringement on the right to consent, and inappropriate surgical procedure. The HPCSA is, however, busy daily with decisions on medical practitioners who are making false claims for services not offered. The number of these types of claims heard by the council outweighs cases on patients' rights infringement.

1006 Beredugo AJ *The role and effectiveness of National Human Rights Commissions in advancing domestic implementation of socio-economic rights* 274-277.
1007 https://nationalgovernment.co.za/units/view/106/health-professions-council-of-south-africa-hpcsa (Date of Use: 3 April 2019).
1008 Health Professions Act No. 56 of 1974.
1009 https://www.immploy.com/2017/12/20/health-professions-council-south-africa/ (Date of Use: 3 April 2019).
1010 https://www.hpcsa.co.za/RecentConvitions (Date of use: 5 September 2019).
1011 Dr ARC Essay MP0355534/716/2009 May 2018.
1012 Dr S Mose MP0612863/19330522 May 2018.
1013 Dr A Botha MP0385492/3714616 May 2018.

6.9.3 The General Medical Council

The register of medical practitioners in the UK is maintained by the General Medical Council (hereafter the "GMC"). Founded in 1858,[1014] the purpose of the GMC is to enable persons who need medical care to have a source to confirm their doctor's qualification or lack thereof. The required qualifications before registration are listed in Schedule A to the Act.[1015] The GMC also releases periodic guidance on how health practitioners should deal with various, thereby cases creating a uniform acceptable approach to healthcare and protecting patients. The decisions of the GMC are also a remarkable example of how the disciplining of medical errors and patients' rights infringements should be addressed.[1016] The reports are detailed and can be used in the education of students in medical and health-related education.

6.9.4 The Care Quality Commission

The CQC is the non-departmental government agency tasked with the regulation and inspection of the health and social services in the UK.[1017] The CQC exists to ensure that all care facilities, including hospitals, care homes, dental and general practices, provide patients with high quality care that is safe and effective. All the care services are mandated to register with the CQC, thereafter the CQC carries out routine and random checks on them through their patients, other users, or inspection of their facilities and services. After inspection, the CQC assigns a rating and puts up the scores of the facility in a prominent place in the facility so that it is visible to all persons who access the service. There have been flawed ratings in some cases where the CQC had given a pass mark to health facilities but subsequent proof of such rating having been ill-considered. The existence of the CQC however keeps the health facilities on their toes. Such rating is recommended and argued to be a yardstick devoid of nepotistic tendencies and corruption in audit procedures.

1014 Medical Act 1983.
1015 Medical Act 1983.
1016 https://www.mpts-uk.org/hearings-and-decisions/medical-practitioners-tribunals (Date of use: 6 September 2019).
1017 https://www.cqc.org.uk/about-us (Date of use: 8 September 2019).

There are also other professional bodies in the UK, in the current research, but the GMC and the CQC are mentioned for specificity and focus.

6.9.5 The Nigerian National Human Rights Commission

The Nigerian National Human Rights Commission (hereafter "NHRC") was established in 1995[1018] to function as an extra-judicial mechanism to protect the human rights of all persons within Nigeria. It was established to domesticate the provisions of the various human rights' treaties[1019] which Nigeria has ratified. Its functions[1020] are to promote and protect human rights; monitor the enforcement of human rights; issue reports on human rights in Nigeria; receive complaints on human rights breaches; investigate them and reach appropriate decisions on them. The NHRC examines laws and regulations to ensure their conformity with human rights laws, undertakes research for the promotion of human rights, and escalates the process of the resolution of violations of human rights with the Attorney General of the Federation. It also acts as a conciliator between parties, visits incarcerated persons to determine their state of dwelling, determines the compensation due to an aggrieved party, and carries out other incidental actions to support its functions. The Commission is required to submit an annual report to the National Assembly and the Presidency on all its activities for the year.

The commission has as its focus the protection of rights of citizens, yet no clear case has been made for the protection of patients, not even in a few cases like its South African counterpart. The commission is evidently more concerned with cases of perceived human rights violations like police brutality and abuse of power, and not with cases of patients who become victims of human rights abuses in various medical facilities spread across the country.

1018 National Human Rights Commission Act, 1995.

1019 The UN Charter; the UDHR, the ICCPR, the ICESCR, the Convention on the Elimination of all forms of Discrimination Against Women, the International Convention on the Elimination of Racial Discrimination, the Convention on the Rights of the Child, the African Charter on Human and Peoples' Rights and other international and regional instruments on human rights to which Nigeria is a party.

1020 National Human Rights Commission (Amendment) Act, 2010, section 5.

6.9.6 Consumer Protection Council (now the Federal Competition and Consumer Protection Commission).

The CPC was established by the 2004 Act to promote, protect and safeguard the rights of consumers of goods and services. The CPC regulates and seeks to modify the output of service providers and manufacturers.[1021]

The duties of the CPC as it relates to patients are as follows:[1022]

- to provide speedy redress for consumer complaints.
- to cause an offending organization to provide compensation to an aggrieved consumer.
- to encourage professional bodies to adopt quality standards designed to safeguard the rights of consumers.
- to ensure that consumer interest receives due consideration at appropriate fora and to provide redress for unscrupulous exploitation of consumers.

For easy access, the FCCPC receives complaints through all platforms, be it online, in person, or across social media and instant messengers. These complaints may be resolved through negotiations, mediations or other non-litigious means. In matters requiring market intervention, hearings and investigations may be carried out.[1023] Findings from these preliminaries may necessitate a civil suit. The founding Act stipulates the procedure for complaints and states that where a complaint is confirmed, the CPC may give the consumer approval to institute a civil action in court for compensation or restitution.[1024] The Commission when it was the CPC created the Patients' Bill of Rights in conjunction with the federal ministry of health. A major challenge is the enforcement capacity of this agency. It does not have the manpower and resources to police a nation with over one hundred and ninety million people[1025] who are potential victims of patients' rights abuse daily. It is the argument of this

1021 http://cpc.gov.ng/about/what-we-do/ (Date of use: 3 April 2019).
1022 Section 2 Consumer Protection Council Act Laws of the Federation of Nigeria 2004 https://www.lawyard.ng/wp-content/uploads/2016/01/Consumer-Protection-Council-Act.pdf (Date of Use: 3 April 2019).
1023 http://cpc.gov.ng/about/what-we-do/ (Date of Use: 3 April 2019).
1024 Section 8 (b) CPC Act.
1025 http://www.fao.org/3/ca5464en/CA5464EN.pdf (Date of Use: 12 May 2020).

thesis that the Ombudsman approach of the HPCSA and the South African government might improve the reach of the FCCPC.

6.9.7 Medical and Dental Practitioners' Tribunal

This Tribunal is the disciplinary body empowered by law to discipline erring members of the medical and dental profession in Nigeria. Where there is an infringement of patients' rights or unethical conduct, the patient is expected to make a complaint via an affidavit and send it to the Medical and Dental investigating panel, which will determine whether the case has any merit. If the case has merit as determined by the panel, it will summon the parties and hear the case. Where it determines that there is no merit, it discards the case. The Tribunal may warn or suspend a medical practitioner or strike out his/her name from the register. One of the major differences between this tribunal and many disciplinary bodies in the other two jurisdictions is that this tribunal has the status of a high court in Nigeria. Appeals from this tribunal go to the Court of Appeal.

The challenge is that the tribunal sits only sporadically, is poorly funded, and does not publish records of its proceedings. The only matters for which it has had to produce its records have been those which have gone on appeal. This is clearly distinct from the fitness to practise panel of the GMC and the HPCSA. The GMC on the other hand, releases a monthly report of decisions with full details of the proceedings of the case. The HPCSA also releases a period decision outline, though this is not as comprehensive as that of the fitness to practice panels, as it only releases basic information such as the name, a summary of the offence and the decision of the panel.

In a report quoting the former registrar of the medical and dental council of Nigeria, he stated that he was worried about an increasing spate of medical negligence cases including that of a doctor who forgot a swab in the abdomen of the patient. He was also worried about fake and unlicensed medical practitioners. This seems to be a distinct problem in Nigeria; whilst the other countries in this

analysis face medical negligence cases, an inconsiderable number of these cases relate to fake medical practitioners.[1026]

Compared to the other jurisdictions, the decisions and outlook of the medical disciplinary tribunal in Nigeria are far from acceptable. For instance, in the disciplinary case of Dr Jamilu Muhammad of the General hospital, Kebbi state, which was reported in a newspaper, the doctor was suspended for six months. His offence was that he carried out unnecessary surgery. He severed the lower limb of a baby and mismanaged the case of a pregnant woman. He diagnosed the baby as being dead, severed the lower limb, and discovered later that the baby was alive and well.[1027] This decision, weighed against the offence may appear as a mere slap on the wrist vis-a-vis the damage and negligence. This misconduct could have earned the doctor an erasure if it occurred in the UK or a longer suspension in South Africa.

Another doctor, Tijani Faruk, in Sokoto state, Nigeria, was alleged to have abused a patient and raped her after administering a sedative to her. He also performed a surgical procedure on her which would prevent her from having children. After a successful fibroid surgery, the reason for which the patient was in the hospital, the doctor blocked the patient's womb. He called the patient's husband to ask that his wife come back for a review and he raped her again. On the wife informing the husband, a sting operation was performed on the doctor, and he threatened the patient with the possibility of losing her home if her husband was made aware.[1028] Sadly, to date, the medical council is yet to conclude the investigation or make any pronouncement on the doctor's registration. An appropriate decision would have been a temporary suspension pending the determination of the investigation to protect other patients and to show a true defence of patients' interests.

1026 Olokor F "Medical council condemns cases of malpractice among doctors" https://punchng.com/medical-council-condemns-cases-malpractices-among-doctors/ (Date of use: 16 August 2019).

1027 http://saharareporters.com/2019/04/28/doctor-suspended-others-await-verdict-medical-council-probes-unethical-practices (Date of use: 16 August 2019).

1028 Jaafar J "Exclusive: how doctor sedated, raped married patient in Sokoto" https://dailynigerian.com/exclusive-how-doctor-sedated-raped-married-patient-in-sokoto/ (Date of use : 16 August 2019).

6.10 Healthcare financing and rationing *vis-à-vis* patients' rights

Health financing is a key component of a well-functioning health system.[1029] Healthcare comes at a cost to the giver or benefactor which may be government, charity organizations, family members or the patients themselves. While, the provision of an enabling environment for the availability of healthcare services with global best practices and adherence to ethics falls squarely on the national, regional or regulatory bodies, the financing of the machinery, facilities, and personnel falls primarily on the governments. Governments need to ensure there is adequate planning for the financing of their health sector in light of their nations' health needs and the realities of the cost of retaining competent healthcare professionals. This includes updating the various machinery and facilities required to match up with the international standards of healthcare. The objective of healthcare financing should be to provide national or universal coverage for all residents. In Nigeria, healthcare is financed by tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community).[1030] Understandably, out- of-pocket payments and insurance come at the point of accessing services or after accessing services. National coverage is internally generated from taxes or sales of mineral resources and should have put those health services in place so that the out-of-pocket payments and insurance are required primarily for its maintenance.

Despite all these sources of revenue for the provision of healthcare, there is still a wide gap between the means and the health needs of many nations. This limited availability of financing for healthcare necessitates the rationing of its provisions, so that some patients may be denied services because of a triage classification. The objective of rationing is the judicious use of resources. This rationing may be applied at four levels, namely, healthcare policymakers, healthcare managers, healthcare providers, and patients.[1031] It can be achieved

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1029 https://www.who.int/healthsystems/EN_HSSkeycomponents.pdf (Date of use: 15 August 2019).

1030 Uzochukwu BSC *et al* "Healthcare financing in Nigeria: implications for achieving universal health coverage" 2015 *Nigerian Journal of Clinical Practice* 437-444.

1031 Keliddar I, Mosadeghrad AM and Jafari–Sirizi M "Rationing in health systems: a critical review" 2017 *Med J Islam Repub Iran* 47.

through a fixed budget, benefit packages, payment mechanisms, queuing, co-payments, and deductibles.[1032]

Triage is the basic approach to categorizing patients into who needs to be attended to first or with which treatment. Triage is the assignment of degrees of urgency to wounds or illnesses to decide the order of treatment of many patients or casualties. Medical practice has advanced to cosmetic procedures and fertility treatments. These two procedures are also subjected to triage analysis in rationing. While there ought to be a standard measure for all patients such that when a patient is deemed ineligible for a treatment or procedure, the deciding authority is not perceived to have breached such patient's right. However, as indicated in chapter four of this thesis, the situation in a country like Nigeria requires some intervention. Rationing in Nigeria is largely done on a basis of nepotism or inadequate medical facilities due to corruption in the management of public funds.[1033] In the UK, rationing is legislated and actionable. NICE determines the rationing by its cost-effectiveness with a widely used measure called a quality-adjusted life year. The premise for this is that the government should spend its limited resources on treatments that do the most good for the money.[1034] In South Africa,[1035] there is no legislation on rationing, but resources are utilized to the extent of availability and a large number of persons do not access services of their own volition. In Nigeria, rationing is not a public policy, but an action carried on by the health facilities' workers independent of regulatory bodies. Hence, some officials of a health facility may opt to admit a patient or not on the excuse that there are no bed-spaces.[1036] The patient will not be attended to at all nor stabilized - just an outright rejection. Then, at the public hospitals,

1032 Keliddar, Mosadeghrad and Jafari–Sirizi: 2017 *Med J Islam Repub Iran* 47.

1033 https://punchng.com/nigerias-low-universal-health-coverage/ See also Ukwu J and Ibeh N "How 15,000 people are denied basic healthcare in Yobe: report" https://www.legit.ng/1208123-how-15000-people-denied-basic-healthcare-yobe-report.html (Date of Use: 3 April 2019).

1034 https://www.pri.org/stories/2010-12-17/how-uk-rations-health-care (Date of Use: 3 April 2019).

1035 https://www.voanews.com/a/south-african-health-care-might-be-rationed-88819887/114493.html (Date of Use: 3 April 2019).

1036 https://punchng.com/inside-nigerian-public-hospitals-where-one-doctor-attends-to-100-patients-per-day/ (Date of use: 12 May 2020).

patients will see the GP but may be sent off to another facility for in-patient treatment if required. Regrettably, this decision may be overturned by nepotism.

In relation to patients' rights, rationing may be considered from the question whether a patient who is denied treatment due to rationing loses any of his/her fundamental human rights in the process or not. If the answer is negative, then rationing in that case may not be considered a breach of the patient's rights. However, where any of the patients' rights will be breached, rationing in that instance should be suspended. An analysis of the impact of rationing on patients' rights must be done on a case by case basis.[1037]

The UK has set up a system that treats patients based on the level of necessity to the patients' recovery and may not contravene the patients' rights provision. The Nigerian method leaves a lot to be desired as patients lose their lives continuously due to the self-regulated rationing by the various health facilities. A 2004 report[1038] indicated that reducing the portion of the UK budget allocated to health to 7% of the GDP put the UK at the bottom rung of the Organization for Economic Cooperation and Development (hereafter "OECD") ladder of nations prioritizing the capacity to deliver healthcare within their systems.

6.11 The effect of health insurance in South Africa and the United Kingdom on patients' rights

Financing healthcare is one of the major obstacles inhibiting patients' rights in the world. It is either the medical care needed is too expensive for the common man or woman, or the pressure on public healthcare has made the waiting queue unbearably long. Either way, one sure answer to healthcare financing is insurance.[1039] Insurance schemes, where they exist in the target countries of this research, will be considered below.

1037 See Mason and Laurie *Law and Medical Ethics* 414-415, where the authors affirm that medical benefit is the most acceptable yardstick for measurement in healthcare rationing and not QALY, age, or social roles.

1038 Boscheck R "Healthcare rationing and patient rights" 2004 *Intereconomics*310-313.

1039 Uzochukwu B *et al* "Healthcare financing in Nigeria: Implications for achieving universal health coverage" http://www.njcponline.com/article.asp?issn=1119-3077;year=2015;volume=18;issue=4;spage=437;epage=444;aulast=Uzochukwu (Date of access: 12 May 2020).

The NHI in South Africa is set up as a non-profit public entity to offer health services to South Africans based on their health needs.[1040] It aims to resolve the inequities of the South African public healthcare system. It offers primary to tertiary healthcare to citizens and legal residents. Beneficiaries need to follow the process to be entitled to full insurance, that is, they need to start the access to service from their general practitioner and be referred, if required. While refugees may be entitled to the services as stipulated by law,[1041] temporary residents may need to get their own insurance.[1042]

The NHS in the UK provides free health services to all persons who have a legitimate presence in the UK, except they are medical tourists, in which case, they must have undertaken to bear their medical bills before they were issued their visas of entry. The NHS is fully developed, and progressive adjustments are made to the system as reality demands. Although blamed for various issues like long waiting times for treatments and reduction in funding leading to rationing against non-critical medical procedures, the UK's NHS still leads the pack in this research. It sets the standards for service delivery, accountability of all practitioners, an approachable complaint system and a quality control system that carries out periodic checks to ensure all health facilities adhere to the regulations.

The advantage of health insurance in the countries mentioned is that it reduces the total refusal of health practitioners to treat as it happens in some countries like Nigeria, or the detention of patients in some jurisdictions. The existence of a functional health insurance scheme guarantees the right to health, right to treatment, some level of dignity, and cover for emergency treatment. This will also aid private health services to recover the cost of treatment where they have treated in good faith or emergency situations.

1040 http://www.hst.org.za/publications/nonhst%20Publications/Booklet%20-%20Understanding %20 National%20Health%20Insurance.pdf (Date of use: 28 February 2019).

1041 Section 27(g) of the Refugees Act 130 of 1998 as amended.

1042 Sithole HL "An overview of the national health insurance and its possible impact on eye healthcare services in South Africa" https://avehjournal.org/index.php/aveh/article/view/18/310 (Date of use: 28 February 2019).

6.12 Litigation and compensation systems

Litigation in healthcare may lie in tort or in suits to compel the government to fulfil an obligation or implement a policy. A suit instituted against a health practitioner or a facility for negligence lies in tort. In tort, the patient may request an injunction to stop an act or claim compensation for a wrong that has already been committed. For a claim to stand, the patient must prove that (s)he was owed a duty of care, which was breached and that the breach occasioned the harm being complained of. The duty of care is established upon the offer of care by the healthcare practitioner or facility. On the breach of duty, health practitioners may not be required to be up to date in their treatments, but where a treatment is standard, and the health worker fell short (s)he may be guilty of negligence or incompetence. The UK case of *Bolam v Friern Hospital Management Committee*[1043] is the *locus classicus* on the duty of care in medical practice. The issue of causation is however a complex one, because of the test of the standard of care expected of the practitioner being sued. The case of *Bolam* established that all that is required is for a body of professionals to confirm what standard was expected of the defendant. If the defendant met the standard, (s)he is not guilty of negligence. In the UK case of *Kay*[1044] the defendant was accused of causing deafness in a patient whom he treated for meningitis with an overdose of penicillin. Even though the defendant admitted he prescribed an overdose of penicillin the court did not find him guilty of tort because deafness is a side effect of meningitis and the cause was not properly established.

With regards to suits to compel the government to fulfil an obligation or implement a policy, there are decisions of the Constitutional Court of South Africa, which largely describe the constitutional right to health as justiciable and enforceable against the state. For example, the case of *Minister of Health v Treatment Action Campaign (No. 2)*[1045] upon which the court ruled on patients' access to nevirapine (a medication which prevents mother-child transmission of HIV/AIDS in pregnant women), the court mandated the State to remove the restriction on the

1043 *Bolam v Friern Hospital Management Committee* 1 WLR 582.
1044 *Kay's Tutor v. Ayrshire & Arran Health Board* [1987] 2 All ER 417.
1045 [2002] ZACC 15.

medication. Until this decision, the medication was available in research facilities only, but not in the public hospitals.

For the UK, Maclean opines that the adversarial system has failed to improve patient care. Litigation may in fact be counterproductive because medical facilities adopt a defensive pattern of care which may be more expensive because elaborate investigations and examinations will be carried out on patients before a diagnosis is given.[1046] Currently, because the management of medical cases is centralised in the NHS, the burden of settlements falls on the NHS. The estimated cost of negligence claims in the UK was about 538 million pounds in 2008 but rose to 1.7 billion pounds in 2017. The number of claims also went from 2,800 to 7,300 in the same years.[1047] There is a prediction that the value of claims may double by 2023.

Unfortunately, medical suits are not commonplace in Nigeria, largely because of the high cost of justice and the poor earning power of the large populace. News articles are replete with tales of negligence and apathy by health workers and facilities, but these discussions are rarely followed up with court suits. Nonetheless, we have a recent case of *University of Ilorin Teaching Hospital v. Dr. Dele Abegunde,*[1048] where the trial court awarded the sum of three million, one hundred and thirty-eight thousand, two hundred and thirty Naira to the applicant as special damages. The judgement and the judge considered, amongst other things, the submission that "the current budgetary allocation of the applicant had been designed for medical care of Millions of Nigerian citizens in line with Federal Government Medical Policy", the applicant being a public teaching hospital. The court further increased the compensation and, in his words, said "I am also of the view that the death caused untold agony, emotional distress, travails and deep trauma attributed to the negligent treatment that resulted in the untimely and avoidable demise of the deceased. The circumstances are particularly traumatic as … and other family members watched as the deceased die from lack of care in a hospital that is a teaching hospital. In

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1046 Mclean SAM, McLean S and Mason JK *Legal and Ethical Aspects of healthcare* (Cambridge University Press Cambridge 2003).

1047 https://www.patientclaimline.com/medicalnegligence/nhs-negligence-claims/nhs-negligence-payouts/ (Date of Use: 18 August 2019).

1048 [2015] 3 NWLR 421.

the circumstances, I award five million Naira as general damages". This case shows that if aggrieved patients or their families follow through with suits and can marshal all legal points required the judiciary will authorise their compensation as appropriate.

Another issue with litigation especially in Nigeria is the delay in court processes. Cases often take years to reach a conclusion, with intervals of several months between one adjournment and another;[1049] this delay discourages a lot of litigants, pushing them to the resolution to “let go and let God”. An additional issue in litigations is the statutes of limitation which proscribes instituting an action in tort after a certain time frame.

6.13 No fault compensation schemes

Whereas litigation is good, an aggrieved patient need not go to court before (s)he is given necessary redress. One of such schemes is the no fault compensation schemes. No fault compensation implies that an injured person is compensated without the need to pinpoint the party at fault.[1050] The No-Fault Compensation Scheme (hereafter “NFCS”) is a public initiative in the UK. It is an alternative to resolving claims against hospitals or medical personnel due to medical negligence. Some of the arguments for a NFCS are that justice will be done, and it will reduce animosity and blame.[1051] Another possible advantage is that it might reduce cost. Cost reduction is arguable, as some authors suggest that it is a more expensive scheme, involving doling out funds because of the difficulty in establishing causation. The schemes are administered by the government and the nature or severity of injury determines the entitlement of the patient to payment. Examples of the schemes are:

i. Criminal Injuries Compensation Authority - this is an executive public agency that was established in 1996 and is based in Glasgow. It administers a compensation scheme for injuries caused to victims of violent crime in England, Scotland and Wales.

1049 https://punchng.com/justice-suffers-delay-in-nigerian-courts-amidst-plenty-it-solutions-2 (Date of use: 30 January 2020).

1050 Https://thelawdictionary.org/no-fault-compensation/ (Date of Use: 29 June 2019).

1051 Herring J *Medical Law* 4th ed (Pearson Education Limited London 2015)18.

ii. Pneumoconiosis (Workers Compensation) Scheme - this was established by the Pneumoconiosis etc (Workers' Compensation) Act 1979 to provide compensation for those sufferers of asbestos diseases in the UK, who are unable to claim compensation from the employers who negligently exposed them to asbestos dust.

iii. Mesothelioma Payments (2008 Scheme) - this enables the UK Department for Works and Pensions to make lump sum payments to people suffering from diffuse mesothelioma, if they were exposed to asbestos in the UK.

The NFCS culminates in a one-off payment when successful. The payment is usually lower than what may have been received through a personal injury compensation claim. In 2001, this was introduced as an option in claims against the UK NHS.[1052] The schemes are designed to settle claims swiftly without the delay caused by lawyers and court procedures. Ambulance chasing lawyers have been identified as creating unnecessary litigation, while the judiciary seems set up to cast blame in matters of claims. The NFCS is a reform that takes the legal costs of claims off the taxpayers.

There is no similar provision in the South African and Nigerian systems. The closest to this is the South African HPCSA Ombudsman, which is created to resolve medico-legal claims using medication and conciliation techniques. The NFC scheme which is more popular, although criticized in Australia and New Zealand, has resolved many cases,[1053] reducing litigation time and bottlenecks, as well as preventing huge damage costs to taxpayers and hospital trusts. The fear in some quarters about decisions of courts against health institutions and practitioners in patients' rights infringement cases is that the decision, which could either be fines, damages or cost awarded, only impoverishes the health system and so affects more patients.

1052 Hodges C "Government proposes tariff no fault compensation scheme for medical negligence" https://www.cms-lawnow.com/ealerts/2001/07/government-proposes-tariff-no-fault-compensation-scheme-for-medical-negligence?Cc_lang=de (Date of Use: 8August 2019).

1053 Foster C *Medical Law A Very Short Introduction* (OUP Oxford 2013) 62-63.

6.14 Mediation and non-litigating approaches to remedying patients' rights infringement

Unlike court actions which are public, alternative dispute resolution procedures like mediation are private and can be tailored to suit parties. Medical practitioners do not need to be vilified for an act which they may not be found guilty of. Similarly, patients may not necessarily need the public in their private health issues. Some patients, in fact, want to see the medical practitioner remorseful and apologetic in a private forum. However, in medical controversies, the medical practitioners have all the facts and professional backing for his acts, while the patient often only has his perception of the outcomes and a few experts to support the patient's perception, which may not be factual. Hence, arbitrators, mediators, and conciliators may be swayed in favour of their professional colleagues and not identify with the interests of the patient. For example, the Nigerian situation where corrupt practices of public office holders have depleted the funds required for the provision of necessities like healthcare, a negligent doctor or nurse may be excused under the prevailing circumstances, namely that the case cannot be treated similarly to one in a country with functioning public systems and processes.

The health Ombudsman in the South African healthcare system has the power to consider, investigate and dispose of complaints in a fair, economical, and expeditious manner.[1054] The Ombudsman's jurisdiction covers complaints against managers or employees of health facilities and against the facilities themselves. The health Ombudsman must act swiftly on complaints, submit reports of investigations to the person who made the complaint and the facility/personnel complained against, and must ensure its recommendations are implemented.

6.15 Conclusion

Overall, the existing frameworks for patient rights within the jurisdictions compared in this thesis are laudable. However, having laws without solid implementation frameworks is as good as having no laws at all. The regulatory

[1054] National Health Amendment Act 2013, section 26(7)(a).

and statutory provisions have set up a solid backdrop against which effective implementation and enforcement should deliver healthcare at its best and promote the rights of patients. This chapter posits that rights are universal and that the concept of rights is known in most jurisdictions as rights have a historical basis in most nations' history. It is also suggested that the choice of government system by a country might determine what level of healthcare service is available to patients and at what cost.

Also considered in this chapter is the African Charter, as a unifying factor for the protection of patients in Africa. The major limitation to its implementation, is that signatories need to domesticate same before it can be enforceable.

As established in this chapter, and in the preceding chapters, the major similarity in the countries considered in this research is that they have a similar common law origin, existing legal and legislative frameworks, and case laws to test the protection of patients' rights. The differences, however, include (a) the fact that in contrast to South Africa and the UK, Nigeria has no legislation specific to the protection of patients' rights; (b) the existence of protection for the patients' rights of traditional healers in South Africa, which is not existent in Nigeria or the UK; (c) there is also a noticeable difference in the decision of courts and level of punishments by the professional ethical bodies in Nigeria; in most cases, the professional ethical bodies are deemed to be too soft on their colleagues; (d) institutional insurance and professional indemnity is not common in Nigeria compared to South Africa and the UK; (e) the UK is open to the no fault compensation scheme, a scheme which is unavailable in Nigeria and South Africa; (f) institutional protection of patients' rights in the UK is more reliable than in Nigeria or South Africa; (g) non-litigation approaches to the resolution of medical claims are more pronounced in the UK and South Africa, as against the practise in Nigeria; and (h) the unitary system of government in UK has aided all round development of her medical institutions as against what is obtainable in Nigeria and South Africa.

Likewise, The UK gives credible information on disciplinary decisions, on a regular basis. South Africa through the HPCSA does the same, though the records are not satisfactorily detailed. The Nigerian situation is, however, a far

cry from the other countries within the scope of this research as it does not publish any record of professional discipline and leaves the public to guess the ratio for its publicised decisions which are few and far between.

In this chapter, the implementation of patients' rights and their protection were compared after close analysis of the three countries' systems. The UK is applauded for the systems put in place to regulate the health service sector and ensuring that their delivery is always on point. The accessibility of the complaint medium and the effectiveness of the attention given to addressing the complaints is a factor which keeps health workers on their toes because they know they may be named by dissatisfied patients as parties to a breach of their patients' rights. The South African situation is also laudable because the right to health is embedded in the Constitution RSA and is enforceable, though within the constraints of availability of resources. For Nigeria, patients may enforce their rights by instituting actions in tort or reporting a breach of the fundamental human rights to the Medical and Dental Council of Nigeria, as well as other health professions regulatory body pending the time the right to health is enforceable.

The effect of health insurance was also discussed in this chapter, as countries with functional health insurance systems seem to give the patient an advantage; the promotion of universal health coverage is an advantage for the patient. The patients' right, especially to healthcare, may be protected where the insurance company is willing to bear the cost. It is mooted by this thesis that the only way to protect a right to treatment and to prevent detention in hospitals, is to ensure that there is universal health coverage via affordable insurance. This chapter also observed that the fear of international sanctions and remaining right in the comity of nations are viable tools to ensure the commitment of signatory-nations to international agreements. This means that International law can be utilized in the bid to protect the rights of patients.

The national enforcement mechanisms and agencies were also identified in this chapter, such as, the NHRC, SAHRC, GMC, FCCPC, HPCSA, CQC. These are pivotal in the protection of patients. However, there is a general apprehension that professional bodies and independent organizations investigating patients' rights infringements must rely on medical professionals in a bid to make their

decisions. Mediation, arbitration, and conciliation, but especially mediation, which is being carried out by the Ombudsman in South Africa is promoted as a solution to unresolved patients' dissatisfaction. The no-fault compensation scheme is also seen as a possible alternative to traditional litigation. It is emphasized that the aim of patients' rights protection is not to hound health workers but to identify patients' rights and protect them.

This chapter concluded that the NHS Constitution is a good example of patients' rights protection. Notwithstanding this, the UK must protect patients by continued regulation of the health sector and improved focus on the private healthcare facilities through the NHS Constitution and various professional ethical guidelines, as more individuals may be willing to pay for their healthcare in a bid to get improved patient experience, yet all citizens must be protected. The advantage of private healthcare regulation is that the public system is genuinely freed up for those who cannot afford the private sector, and those who require shorter waiting times have continued access to the private sector. Consequently, rationing may be less damaging to patients' care as less demand on the public sector will increase the reach of the funds allocated to healthcare in the UK as in other countries.

As regards the Nigerian situation, it has defied economic and social policies. There is a need for an impartial judiciary to make exemplary decisions on the rights of patients and ensure successful prosecution of those who divert funds for health or import substandard or damaged machinery into the country. Such illegal and unethical practices have a direct and indirect impact on the life and rights of the patient.

For South Africa, a wider reach of the existing NHI is recommended as a panacea to continued infringement of patients' rights. The HPCSA and the Ombudsman must also reach the patients and engage in active patient protection with improved details on actions against practitioners who have infringed on the rights of patients. Lastly, the traditional health sector, which is an alternative for the people, should be brought under proper regulation so that it is as reliable and protective of patients' rights as orthodox medical practice.

CHAPTER 7: PATIENT'S RIGHTS AND GLOBAL BEST PRACTICES

7.1 Introduction

In the previous chapters, I examined patients' rights across three jurisdictions. In chapter six, I attempted a contradistinction between the healthcare practices in the three countries and concluded that, although the UK system on the protection of patients' rights is the best of the three jurisdictions, it is not perfect as it faces various challenges. The medical practice and protection of patients' rights in South Africa is relatively fair, and the practice in Nigeria is deemed poor. I equally recommended that there is the need for an international law that can be adopted and become enforceable in all countries, regardless of the *lacunae* in individual national laws. That is the take off point for this chapter of the research.

An international model instrument cannot be proposed without first considering the existence and potency of subsisting international and regional laws, as a guide to the enforceability and effectiveness of international laws. The aim of the chapter is to determine what makes international instruments largely ineffective in the protection of patient's rights and correct that defect in the suggestion of a new model international law for such protection.

In a bid to fulfil the aim, I start by discussing what global best practices are concerning patient's rights. I then consider existing international and regional laws in a bid to determine their effectiveness and enforceability. The international instruments I focus on include: the UDHR, which protects human rights as a whole, the Declaration of Geneva which focuses on the ideals of medicine, the Declaration of Venice which caters for the medical care of the terminally ill, the WMA Declaration of Lisbon on the Rights of Patients, the European Charter of Patient's Rights, the African Charter on Human and People's Rights which is a continental legislation but is focused on the rights of people in general, as well as the European Convention on Human Rights 1998. I further examine state endorsed infringement of rights and consider the protection of patients in private healthcare *vis-à-vis* public health systems. This is to determine which of the systems protects patients' rights more effectively. All these will be the foundation

for the discussion of the codification of a proposed global patients' right law, taking into cognizance the global best practices in healthcare.

Being the final chapter on the aims of this thesis, and immediately preceding the final resolution of this thesis, this chapter contains the final arguments on the need for a global legislation on the protection of patients' right. This can, where the legislation in any member country that is a signatory to the legislation is weak, serve as substitute legislation, as this will be adequate to protect the rights of patients around the globe, regardless of their nationality, designation or status. For the institutionalisation of patients' rights laws, it must be transnational and without boundaries.

7.2 Global best practices in the protection of patients' rights

One of the major aims of this research is the need for the protection of patients' rights in an enforceable international instrument, hence the need to assess global best practices. Global best practices as it relates to health services, refers to the highest level of health service provision enjoyed by patients in any location within the globe. The assumption is, if it can be implemented for a patient in a location, then it may be duplicated and implemented elsewhere too and, where such adoption of standard practice is transferred, patients may receive the best possible care anywhere in the world. This is based on the knowledge that professional skills required to deliver health services can be acquired, and the knowledge is transferable. Also, the non-clinical support, usually administrative and procedural which are obtainable under the highest health service provision, can be replicated elsewhere. Therefore, if there is a certain level of healthcare being delivered in a certain jurisdiction, if all the factors that culminate in its delivery are available in another jurisdiction, the same standard should be experienced by all patients in the other jurisdictions, other things being equal as well.

In a bid to determine what global best practices is, there is the need for a deliberate attempt to evaluate laws whose application extends to more than one country, and the effect of such laws on variables such as healthcare and patients' rights. The existing statutes and regulations that converge in their application to

deliver excellent healthcare were presumably drafted by legislators, scholars, healthcare practitioners and international legal experts who have either been exposed to excellent healthcare delivery or can scientifically predict that if some factors are put in place, the ideals of those documents are achievable. The main factors in fulfilling the ideals are the human and capital resources. Provisions relating to patients' rights in most jurisdictions are achievable. The bottle necks currently being experienced across the globe lie with the functionaries saddled with the administration of the public offices. To a large extent, the public office holders determine which portion of the budget goes to which sector[1055] and they approve all major recruitments and machinery acquisitions. Thus, the first place to begin an enforcement of global best practices is to hold public office holders accountable. The three countries that have been compared in this research have some accountability methods and yardsticks for public office holders to a similar degree.[1056] The UK is an enlightened society with public office holders held on tight reins of accountability, while South Africa and Nigeria somewhat need to do more as was revealed in the previous chapters. Where the level of accountability is higher, the service delivery is better and *vice versa*. In a true democracy, power is given to the people. When the people have a say in their governance, not just at election periods but throughout the tenure of the office holders, the interest of the masses, including patients, who are part of the populace, will enjoy better protection.

A foundation to considering global practices in the protection of patients' rights, is the examination of international instruments protecting these rights, highlighting their areas of strength and weaknesses. Some of the international laws on the protection of patients' rights are considered below.

1055 HM Treasury https://www.gov.uk/government/publications/spending-round-2019-document/spending-round-2019 http://www.treasury.gov.za/documents/National%20Budget/2019/ (Date of use : 1 December 2019).

1056 The parliaments of SA, UK and Nigeria often act as check on the government cabinet.

7.2.1 United Nations Universal Declaration of Human Rights 1948

The UDHR is a document which outlines human rights. It was adopted by 48 member states of the UN in Paris on the 10th of December, 1948.[1057] There were 58 member states in the UN at the time of its adoption and none voted against it, although 10 member states did not vote in support of its adoption.[1058] The Declaration is premised on the recognition of the inherent dignity, equality and inalienability of rights of all humans, and is deemed a foundation of freedom, justice and peace.[1059] The Declaration consists of 30 articles which affirm the rights of individuals. Although there is no direct mention of patients' rights in the declaration, the rights protected by the UDHR bearing direct relevance on patients' rights include the right to freedom from discrimination;[1060] the right to life;[1061] the right to dignity of human person;[1062] the right to privacy;[1063] the right to freedom of movement;[1064] and the right to freedom of religion and belief;[1065] which are all protected by the right to access justice through courts of law[1066] and the right to a fair trial.[1067] All these rights are rights that can be applied to and instrument to the protection of the rights of patient to healthcare.[1068] All these rights are inalienable.

Some organizations were set up primarily to further the objectives of the Declaration namely: The International Federation for Human Rights; Amnesty International; the Unitarian Universalist Service Committee; the Quaker United Nations Office; the American Friends Service Committee; the American Library Association and Youth for Human Rights International. These organizations educate different sectors of the public on the articles of the Declaration. Although

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1057 https://www.un.org/en/universal-declaration-human-rights/ (Date of use: 18 November 2019).

1058 Morsink J *The universal declaration of human rights: Origins, drafting and intent* (University of Pennsylvania Press Pennsylvania 2000) 26-28.

1059 The Preamble to the UDHR.

1060 UDHR, Articles 1, 2 and 7.

1061 UDHR, Article 3.

1062 UDHR, Article 5.

1063 UDHR, Article 12.

1064 UDHR, Article 13.

1065 UDHR, Articles 18 and 19.

1066 UDHR, Article 8.

1067 UDHR, Article 10.

1068 The nexus between human rights and patients' right has been succinctly discussed in chapters 2, 3, 4, and 5 of this research.

the Declaration itself may not be considered binding, it has been the reference point for binding instruments in the international, regional and national spheres.[1069] Some authors consider these references to the Declaration as an indication that the document is part of the customary international law.[1070] All three jurisdictions considered in this research are members of the UN,[1071] ratified the instrument[1072] and are therefore subject to the UDHR. However, as noted above, the UDHR is, in itself non-binding.[1073] The importance of this declaration to patients' rights is that it serves as a strong pivot for rights claims across the world and its universality in use aligns with the object of this thesis which suggests that the existence of a universally applicable law protecting patients will have coverage across continents.

7.2.2 The International Covenant on Civil and Political Rights

One of the international instruments influenced by UDHR is the ICCPR. This is a multilateral treaty which was adopted by the UN General Assembly in 1967 and came into force in 1967. Although its primarily aim is contained in provisions regarding the civil and political rights of individuals, it recognizes some ancillary rights which can be adopted to protect patients' rights.[1074] The ICCPR provides for freedom from discrimination,[1075] although with regards to the enjoyment of civil and political rights; the right to life;[1076] freedom from torture;[1077] the right not to be enslaved;[1078] the right to liberty and security of persons;[1079] protection of

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1069 Von Bernstorff J "The changing fortunes of the universal declaration of human rights: Genesis and symbiotic dimensions of the turn to rights in international law" *The European journal of International Law* 2008 903-924.

1070 See generally Steiner HJ, Alston P and Goodman R *International Human Rights in Context: Law, Politics, Morals* 3rd ed (Oxford University Press New York 2007) 736 and Hannum H "The universal declaration of human rights in National and International Law*"* 1998 *Health and Human Rights* 145.

1071 The UK joined the UN in 1945, South Africa also joined in 1945 and Nigeria joined in 1960.

1072 The UK ratified the UDHR in 1951, South Africa ratified same in 1996 and Nigeria in 1993 via the Nigerian Ratification and Enforcement Act of 1983.

1073 https://www.amnesty.org/en/what-we-do/universal-declaration-of-human-rights/ (Date of use: 18 November 2019).

1074 Articles 2,3,6,7,9,11,12,13,14,18,19 ICCPR.

1075 Articles 2 & 3.

1076 Article 6.

1077 Article 7.

1078 Article 8.

1079 Article 9.

the rights of detainees;[1080] the right not to be imprisoned for failure to fulfil contractual liabilities;[1081] the right to a fair hearing;[1082] the right to freedom of thoughts, conscience and religion;[1083] and protection of the rights to hold opinions without interference.[1084] In addition, there are ancillary rights which relate to the freedom of movement[1085] and the rights of aliens.[1086]

The ICCPR, by article 2(2), charges the state parties to take necessary steps and measures to give effect to its provisions. This can form part of the challenges for a global patients' rights law, as countries must bend their sovereignty to adopt international law. However, once they have adopted the law, it becomes binding. The implication of waiting for countries to give effect and enforcement to this covenant is that there is no enforcement mechanism imbued in the covenant. All three countries considered in this research are members of the UN and thus subject to the provisions of this covenant.

7.2.3 Declaration of Geneva

The Declaration of Geneva is a declaration of a physicians' allegiance to the noble ideals of medicine. The need for this allegiance was brought to the fore in the wake of the medical crimes committed in the German occupied Europe during the Second World War.[1087] The Declaration is an improvement on the Hippocratic Oath and is considered a pledge by the WMA.[1088] This is fundamental because

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1080 Article 10.
1081 Article 11.
1082 Article 14.
1083 Article 18.
1084 Article 19 See also https://ccla.org/summary-international-covenant-on-civil-and-political-rights-iccpr/ (Date of use: 18 November 2019).
1085 Article 12.
1086 Article 13.
1087 Between 1939 and 1945 when the Nazi occupied Europe, they committed a lot of atrocities against people. The Nazi Doctors' trial at Nuremberg exposed a lot of things that needed to be regulated. See generally https://www.ushmm.org/learn/introduction-to-the-holocaust/path-to-nazi-genocide/chapter-4/world-war-ii-and-the-holocaust-1939-1945 (Date of use: 18 November 2019); Douglas RM "The European atrocity you never heard about" https://www.chronicle.com/article/The-European-Atrocity-You/132123 (Date of use: 18 November 2019). Also, key a influence is the act of the Japanese doctors under the Japanese Imperial Army at Unit 731 in China. See generally Ivy AC "The history and ethics of the use of human subjects in medical experiments" *Science* 1948 1-5.
The WMA is an independent and international confederation of free professional medical associations of different nationalities. The purpose of the WMA is to serve mankind by endeavouring to achieve the highest international standards in medical education, ethics and healthcare. See https://www.wma.net/policies-post/wma-declaration-of-geneva/ (Date of use: 7 May 2019).

the Hippocratic Oath, although valid in its own rights, was deemed inadequate in addressing the realities of modern medicine. The Declaration reads:

> AS A MEMBER OF THE MEDICAL PROFESSION: I SOLEMNLY PLEDGE to dedicate my life to the service of humanity.
>
> THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration.
>
> I WILL RESPECT the autonomy and dignity of my patient.
>
> I WILL MAINTAIN the utmost respect for human life.
>
> I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.
>
> I WILL RESPECT the secrets that are confided in me, even after the patient has died.
>
> I WILL PRACTICE my profession with conscience and dignity and in accordance with good medical practice.
>
> I WILL FOSTER the honour and noble traditions of the medical profession.
>
> I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due.
>
> I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare.
>
> I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard.
>
> I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat.
>
> I MAKE THESE PROMISES solemnly, freely and upon my honour.

It is important to add that the Declaration of Geneva is indirectly a legally binding physician code in many countries around the world – mostly subject to the jurisdiction of professional committees. This is because the Declaration enforces a professional ethical standard. This Declaration as stated above, is the 9th revision of the original Declaration in 1948 and was passed unanimously in the

WMA 68th General Assembly in 2017.[1089] The limitation of implementation of this Declaration is the reporting mechanisms of alleged breaches and the screening and hearing of same. Currently, the WMA consists of 111 national member associations. The UK,[1090] Nigeria,[1091] and South Africa[1092] are all members of the WMA[1093] and therefore subject to the contents of this Declaration which relates to the protection of patients' rights and the advancement of healthcare in general.

It is also noteworthy to add that the Declaration of Geneva has given rise to the International Code of Medical Ethics. This Code became a form of an extension of the Declaration. This Code, as the name suggests, establishes ethical principles to be followed by physicians globally, and focuses on duties of the physicians to their patients and colleagues. It was originally adopted by the WMA General Assembly in 1949 and was further amended in 1968, 1983 and 2006. This Code considering its spread, is one of the closest attempts by nations for a universal code for managing medicine and physician conduct. It is unfortunately a mere pledge reviewed time after time but has not been the basis for conviction of any professional by itself within the member countries. This thesis advocates that there must be a law which is binding and domiciled in as many countries as have adopted the Declaration of Geneva and even possibly in more countries for the benefit of their citizens.

7.2.4 Declaration of Venice

The Declaration of Venice is the WMA's declaration centred on the physicians' obligation to the terminally ill. It was adopted by the WMA in 1983 but revised in 2003.[1094] The stipulations in the Declaration are to regulate palliative measures that could be put in place when the prognosis of a patient is terminal. In its preamble, it is stated that the final phase of life is critical. Although medicine is

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1089 Kunzmann K "Revised declaration of Geneva could replace Hippocratic oath" https://www.mdmag.com/medical-news/revised-declaration-of-geneva-could-replace-hippocratic-oath (Date of use: 18 November 2019).

1090 In the form of the British Medical Association.

1091 In the form of the Nigerian Medical Association.

1092 In the form of the South African Medical Association.

1093 https://www.wma.net/who-we-are/members/members-list-printable/ (Date of use: 18 November 2019).

1094 Adopted by the 35th World Medical Assembly, Venice, Italy, October 1983 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006.

curative, there are instances where there are no known – or patient accepted – treatments. The Declaration of Venice ensures that such patients spend their final days in the circumstance, under watchful eyes of medical practitioners. The Declaration stated basic principles to guide the physicians in all end-of-life cases. These are:

- The primary role of a physician is to heal and relieve suffering. This role should not be suspended in the case of terminally ill patients.
- Physicians to terminally ill patients have an obligation to assist them pass on with dignity by offering them palliative care which allows them to live optimally and supporting their psycho-social needs.
- Although the patients right to autonomy to decide to consent to treatment or not or to opt for palliative care are still upheld even when such patient is terminally ill, physicians are not to actively assist a patient to die, even where the patient's choices may accelerate dying.
- Physicians must not subject the patient to any process that will be of no benefit to the patient.
- The right of the patient to put his or her near death wishes in writing in advance, or to appoint a proxy to decide on such patient's behalf, must be respected by the physician. When the patient is no longer able to communicate these wishes, the physician, or the proxy, must be part of the decision-making team until the patient passes.
- Physicians must give regard to the terminal patients' psycho-social needs and must provide emotional and spiritual support as required for the patient and her family in her final days.
- The relief of pain within medical guidelines should be adhered to without fear of legal repercussion to physicians.
- National Medical Associations should encourage their governments to commit resources to research on treatments in

terminal case. Medical schools must ensure palliative measures for terminally ill patients are part of the curricula.

- National Medical Associations should foster collaboration with other nations to develop treatments for terminal patients.
- Physicians may support organs of terminal patients artificially for organ donations in line with ethical guidelines.[1095]

The Declaration acknowledges that cultural considerations, required technologies and finances for medical bills influence the process a terminal patient undergoes; hence, a comprehensive guideline may not be practical.[1096] The patient's rights at the end of life are expected to be protected by this Declaration. It is significant to note that end of life decisions differs in different countries and not all countries accept a patient's right to make decisions at the end of life especially the decision to die. It is suggested that death with dignity, continued support at the palliative stage and care for the terminally ill must be emphasized by all patients' rights documents and the proposed patients' rights bill must have provisions to protect all citizens of the world when they are at the end of life.

7.2.5 World Medical Association Declaration of Lisbon on the rights of the patient

This Declaration spells out the need for physicians to protect the patients' rights and autonomy, while delivering their services in the best interest of the patient. This Declaration is instructive for physicians and other persons in the health sector to uphold the rights of patients. It further enjoins physicians to restore patients' rights even when governments seek to infringe or breach the rights. The Declaration spells out 11 principles which are as follows:

- Every patient has equal right to medical care in the patient's best interest. There should be no discrimination. Quality assurance must be ensured. In cases of triage or rationing,

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1095 https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/ (Date of use: 9 May 2019).

1096 https://www.wma.net/policies-post/wma-declaration-of-venice-on-terminal-illness/ (Date of use: 9 May 2019).

choice must be made based on medical criteria with no discrimination.

- The patient has a freedom of choice and may switch hospitals or doctors during treatment or get additional opinion from other doctors.
- The patient has the right to self-determination. (S)he may opt out of treatment. (S)he has the right to refuse to be part of research or teaching aid.
- An unconscious patient still has a right to make a choice through a legal representative. In the absence of the latter, the patient's previous instructions on similar procedures may be adapted or the physician should act in the patients' best interest. Nonetheless, patient unconscious from suicide attempts, should still be revived.
- In the case of minors or other legally incompetent patients, their legal representatives may make decisions for them. But the legally incompetent patient must still be involved in the decision-making process. Where the patient decides to take a decision himself/herself irrespective of what the legal representative decides, the physician should seek power to act in the best interest of the patient from legal authority.
- Diagnostic procedures or treatment against the patients must be done with approval from a legal institution and in line with medical ethics.
- The patient has a right to the information in such patient's medical records except if such information concerns a third party or will be hazardous to the patient. The patient may also authorize the release of the information to a third party.
- The patients' records must be kept confidential even after death. Descendants may be permitted access only to the extent of knowing their medical vulnerabilities. The patient must give express consent before such patient's records are released to third parties except if the law permits otherwise. Where the

record is in a human substance or other form of data, it must also be protected as appropriate so that no information may be withdrawn from it without consent or the backing of a legal provision or institution.

- Everyone has a right to health education to understand how to live healthy and the implication or cause of illness so that they can make informed decisions regarding medical treatment and procedures. And to be aware they have a primary responsibility for their health. Physicians should make health education part of their outputs.
- Patients have a right to dignity. They are entitled to be relieved from suffering and to a dignified passing in case of terminal illnesses.
- Patients have a right to accept or decline spiritual or moral support with regards to their religion.[1097]

This Declaration is subject to the same limitation as the Geneva Declaration, as its adoption by countries will determine its efficacy and there are no specific punishments for breach or remedy except those acknowledged by national laws. An adherence to this by all nations would go a long way in putting patients in control of their medical decisions and protect patients' rights. This is, however, not the current case as this Declaration is only good will and intentions without the force of law to punish breach, determine sanctions and remedy wrongs. The Declaration mentions the right of patients to equality which currently is hard to measure, or protect, as patient discrimination is still rampant in medical facilities including in countries that are signatories to this Declaration.

7.2.6 European Charter of Patient's Rights

The European Charter of Patients' Rights was drafted in 2002 by the Active Citizenship Network and was signed by 12 citizens' organizations from different

1097 https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/ (Date of use: 10 May 2019).

European Union countries, which included the UK until 31 January 2020.[1098] The Charter is aimed at shaping healthcare delivery, and an attempt to translate regional documents on rights to a healthcare specific provision.[1099] The Charter lists the inalienable rights of patients.[1100] These are:

- A right to preventive measures (interestingly this seems to apply to all persons irrespective of the status of their health). The provision is to the extent that every individual has a right to living a life in a way that illness is avoided and a right to take preventive measures against ill health.
- The right of access: everyone has the right to access healthcare irrespective of their financial status, where they live, the nature of the illness or the time of the day they choose to seek service.
- The right to information: everyone has the right to information on their own health status, the available treatments and other innovations in health and technology which may be of benefit to them.
- A right to consent: Every individual has a right to all the information required for him/her to make an informed choice and be given all information relevant to the treatment or procedure. This includes scientific research procedures.
- A right to choose: The patient has a right to choose between different treatments and which physician (s)he wants to attend to him/her.
- Every patient has the right to confidentiality of his/her records and confidentiality while undergoing consultations, procedures or other forms of treatment.
- A right to respect for his/her time: patients have the right to be attended to swiftly at every level or phase of their consultation and treatment.

1098 BBC "Brexit: UK leaves the European Union" (2020) https://www.bbc.com/news/uk-politics- 51333314 (Date of use: 1 February 2020).

1099 https://www.hhrguide.org/2014/02/20/table-1-1-codification-of-patients-rights/ (Date of use: 18 November 2019).

1100 http://www.activecitizenship.net/patients-rights/projects/29-european-charter-of-patients-rights.html (Date of use: 18 November 2019).

- A right to the observance of quality standards: patients have the right to access services provided in compliance with set regulatory standards.
- A right to safety: patients has the right to standard service devoid of errors, safety issues and poor service delivery.
- A right to innovation: each individual has a right to innovative procedures or diagnostic processes that comply with international standards and are devoid of financial commitments.
- A right to avoid unnecessary suffering and pain: patients have the right to avoid suffering and pain at different phases of their illness.
- A right to personalized treatment: patients have the right to treatments tailored to their needs.
- A right to complain: patients have a right to complain when they have suffered harm and a right to feedback on the complaint.
- A right to compensation: where an infringement of patient's rights has caused physical, psychological or emotional trauma, the patient is entitled to speedy compensation.

Although a strong network of patients' rights groups has successfully lobbied for the recognition and adoption of these rights, the Charter is itself not legally binding. The Charter has also been used as a reference point and a standard to monitor and evaluate healthcare systems in Europe.[1101]

Additionally, there is a Cross Border Healthcare Directive which was adopted by the European Parliament.[1102] It covers the healthcare of temporary visitors to a European Union nation, persons living on borders, people seeking medical attention abroad, persons on national assignments abroad and those retiring abroad. The directive mandates reimbursement in some cases and contact points for treatment abroad in other cases. There is also the right to healthcare in other

1101 https://www.hhrguide.org/2014/02/20/table-1-1-codification-of-patients-rights/ (Date of use: 18 November 2019).

1102 Legido-Quigley *et al* "Cross-border healthcare in the European Union: clarifying patients' rights" 2011 *BMJ* 364-367.

European Union states. Summarily European Union citizens have the right to access healthcare in any European Union country and to be reimbursed for the healthcare abroad by their home country. This is the Directive 2011/24/EU on Patients' rights in cross border healthcare. The cost provided, covers cost of treatment and prescriptions as well as the purchase of medical devices. The directive is further enhanced by the interconnected systems and policies in the European Union. Therefore, information on available healthcare, alternative healthcare and/or specialized treatment abroad is easier to access. This Charter strikes a balance between maintaining the sustainability of health systems, while protecting the rights of patients' who seek healthcare outside their home countries. It creates a network of national contact points, provides for cross border prescription and further develops the European Reference Networks, with the added advantage of health technology assessment and e-health.[1103]

7.2.7 African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights was drafted in Banjul Gambia. It was approved by Heads of States in the Organization of African Unity and it entered into force in 1986. The Charter was set up to capture the African culture and tradition as it regards human rights.[1104] The main features of the Charter are as follows:

- all rights are indivisible and socio-economic rights are justiciable.[1105]
- derogations are not permitted except in consideration for others.[1106]

1103 https://ec.europa.eu/health/cross_border_care/overview_en (Date of use: 18 November 2019); see also European Commission "Member state data on cross-border patient healthcare following Directive 2011/24/EU: tear 2017" https://ec.europa.eu/health/cross_border_care/docs/2017_msdata_en.pdf (Date of use: 18 November 2019).

1104 Heyns C and Killander M (eds) *Compendium of key human rights documents of the African Union* 5th edn (Pretoria University Law Press South Africa 2013) 29-41.

1105 *Social and Economic Rights Action Center & the Center for Economic and Social Rights v.Nigeria* (Communication No. 155/96) https://www.escr-net.org/caselaw/2006/social-and-economic-rights-action-center-center-economic-and-social-rights-v-nigeria (Date of use: 13 May 2019).

1106 *Article 27(2) Media Rights Agenda and Others v Nigeria* (2000) AHRLR 200 (ACHPR 1998) http://www.achpr.org/files/sessions/28th/comunications/224.98/achpr28_224_98_eng.pdf (Date of use: 13 May 2019).

- the Charter recognizes group rights, for example, a groups' right to self-determination.[1107]
- individuals and states have duties under the Charter.[1108]

Article 30 established the African Commission on Human and Peoples' Rights to promote human and people's rights and ensure their protection in Africa. This commission is charged with the oversight of the Charter. The Commission was established in 1987 with its headquarters in Banjul. Likewise, a protocol was adopted in 1998 which resulted in the creation of the African Court on Human and People's Rights. This court has made some regional decisions which are deemed exemplary of what is expected in patients' rights protection. Where citizens, groups or nations are unable to get respite, it is expected that they will approach regional and international courts. This is the basis for the argument in this thesis that the protection of patients in international law will give patients a chance to present their cases for breach of patients' rights to courts like the African Court on Human and People's Rights.

However, in the face of all these institutions, the provision of the Charter is being violated. In Nigeria for example, some members of the Ogoni tribe were executed in 1995 pursuant to a court judgement and sentence. They had been accused of murdering another faction within their tribe. Sadly, while in detention, they required medical attention but were denied.[1109] The Commission of Human Rights held that the non-treatment of these deceased persons while in detention contravened article 5 of its founding Charter,[1110] which stated that every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his/her legal status. All forms of exploitation and degradation of man particularly slavery, slave trade, torture, cruel, inhuman or degrading punishment and treatment shall be prohibited.[1111] The Commission also stated that the right to life under the Charter was breached by the denial of medication

1107 http://www.achpr.org/communications/decision/276.03/ (Date of use: 13 May 2019).
1108 Preamble of the ACHPR.
1109 *International Pen and Others. on Behalf of Saro Wiwa v. Nigeria* AHRLR 212 (ACHPR 1998); Communications 137/94, 139/94, 154/96 and 161/97.
1110 ACHPR.
1111 Article 5 ACHPR.

while in detention. The manner the Nigerian government managed the deceased through its public officials left a lot to be desired, as there was a clamour of an appeal against the sentence, but it was still carried out for flimsy reasons such as claims that the accused persons were unable to disprove the allegations that they killed other members of their tribe. This contravenes the legal position that accused persons are considered innocent until proven guilty. It was a positive note that the Commission took note and spoke on the denial of medication to these deceased persons. This shows that their right to health was not meant to be suspended because they were undergoing trial. Additionally, a study carried out in Egypt in 2013[1112] showed an ignorance of the right to health by the populace. Three-quarters of the patients interviewed for the research did not know that patients had peculiar rights. This is notwithstanding that Egypt, like many countries in Africa, had ratified the African Charter since 1984.[1113]

7.2.8 European Convention on Human Rights 1949

This is an international human rights treaty between the 47 Council of Europe member countries to protect the rights and freedoms of persons in Europe. This was an upshot of the impact of the Second World War on Europe, and its aim is to prevent governments from dehumanizing and abusing people's rights with impunity.[1114] The European Convention on Human Rights (hereafter "ECHR") has 18 articles, however, those relevant to the protection of patients' rights include: the right to life;[1115] the right to freedom from torture and inhuman or degrading treatment;[1116] freedom from slavery or forced labour;[1117] the right to liberty and security;[1118] respect for private and family life;[1119] freedom of thought,

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1112 Abou Zeina HA *et al* 2013 *JERHRE* 46-52. (first time?)

1113 State Parties to the African Charter http://www.achpr.org/states/ (Date of use: 15 August 2019).

1114 Amnesty international UK "What is the European convention on human rights?" https://www.amnesty.org.uk/what-is-the-european-convention-on-human-rights (Date of use: 18 November 2019).

1115 ECHR, Article 2.

1116 ECHR, Article 3.

1117 ECHR, Article 4.

1118 ECHR, Article 5.

1119 ECHR, Article 8.

belief and religion;[1120] protection from discrimination in respect of the rights protected in the act;[1121] and the prohibition of abuse of rights.[1122]

The creation of the Convention also led to the establishment of the European Court of Human Rights in 1959. The court is based in France and exists to safeguard the ECHR, providing a forum for a fair hearing and, where any right has been breached, a redress. The judgements of the European Court of Human Rights are binding on the governments of the 47 states who are signatories to the Convention. Making the Convention a powerful living instrument whose decisions have influenced laws and practices of governments across Europe.[1123] The execution of any judgement against a government by the court is supervised by the Council of Europe's Committee of Ministers. Countries found to have breached the rights of the citizen(s) will have to provide justice to them and put processes in place to avoid a continuation or repetition.[1124]

7.2.9 The Human Rights Act UK

The Human Rights Act was passed into law in the UK in 1998. The Act sets out the rights and freedoms everyone in the UK is entitled to. This is a form of domestication of the European Convention on Human Rights into domestic British law.[1125] This is a human rights centred Act and, like related human rights instruments, it protects human rights in general, but the patient centred rights contained therein include: the right to life;[1126] the right to freedom from torture and inhuman or degrading treatment;[1127] freedom from slavery or forced labour;[1128] the right to liberty and security;[1129] respect for private and family life;[1130] freedom

1120 ECHR, Article 9.
1121 ECHR, Article 14.
1122 ECHR, Article 17.
1123 Amnesty international UK "What is the European convention on human rights?" https://www.amnesty.org.uk/what-is-the-european-convention-on-human-rights (Date of use: 18 November 2019).
1124 https://www.echr.coe.int/Documents/Convention_ENG.pdf (Date of use: 20 May 2019).
1125 Equality and human rights commission "The human rights act" https://www.equalityhumanrights.com/en/huamn-rights/human-rights-act (Date of use: 18 November 2019).
1126 Human Rights Act, Article 2.
1127 Human Rights Act, Article 3.
1128 Human Rights Act, Article 4.
1129 Human Rights Act, Article 5.
1130 Human Rights Act, Article 8.

of thought, belief and religion;[1131] protection from discrimination in respect of the rights protected in the act;[1132] and an abolition of the death penalty.[1133]

The implication of the provisions of this Act is that where any of these rights are infringed upon, redress can be sought in a British court. Likewise, all new and proposed laws must be compatible with the Act before they can be passed in parliament. It also regulates executive activities of the government, in that, the government must align its activities with the provisions of the Act. All public authorities or bodies exercising public functions are required to comply with the provisions of the Act. Where any public authority or body breaches the human rights of individuals or groups, the victims have the right to bring a claim against such authority or body. People living with mental health issues also must be related with in compliance with the Act. So, all authorities inclusive of the police and public health workers must interact with mental health patients with caution and in line with the Act.[1134] It is evident from the above that the UK has credible international instruments protecting patients' rights. The European Charter on Patients' Rights and the European Convention on Human Rights are both enforceable instruments that have influenced the protection of patients' rights in the UK. Nigeria and South Africa on the other hand, do not have the same privilege as do the UK. This is because, the only regional instrument that can be adopted in the protection of patients' rights in these countries, the African Charter on Human and People's Rights, is subject to ratification and domestication by member nations. The African Commission on Human and Peoples' Rights created by article 30 of the Charter, has proven to be a failure also. Equally, the UNDHR, the ICCPR, the Declaration of Geneva, the Declaration of Venice and the Declaration of Lisbon are all lofty and noble conventions, but with a major deficiency, they are not enforceable in themselves. This had watered down the importance of these instruments, although they provide a guide for national and regional instruments on patients' rights.

1131 Human Rights Act, Article 9.
1132 Human Rights Act, Article 14.
1133 European Convention on Human Rights 1998, article 1 of Protocol 13.
1134 Equality and human rights commission "The human rights act" https://www.equalityhumanrights.com/en/huamn-rights/human-rights-act (Date of use: 18 November 2019).

In some instances, the state is neither decisive nor punitive in redressing infractions of patients' rights by health workers. Where the state does not use its power to compel that the rights of patients be honoured, the state may be guilty of endorsing the infringement of rights. Likewise, some of the corporal approaches to extracting information from criminal suspects are a direct infringement of the rights of these suspects who are meant to be innocent until proven guilty. An incarcerated patient has rights, as well as a patient who is not a convict of any crime. These rights are enjoyed because they are humans and not because of their status of liberty. Prisoners also do have rights, although they have lost their right to freedom of movement.

7.3 Sustainable development goals and the right to health

Resolution 53/202 was adopted by the UN's General Assembly to convene the millennium summit of the organization. At this summit in September 2000, the Millennium Declaration was ratified by all 189 UN member countries. The declarations are a set of objections upon which the Millennium Development Goals (hereafter "MDG"s) were anchored.[1135] The MDGs expired in 2015 but were replaced by a set of goals referred to as the Sustainable Development Goals (hereafter "SGD"s).[1136] The third goal in the SDG list is the goal to, "ensure healthy lives and promote well-being for all at all ages".[1137] These goals were set in 2015 to be achieved by 2030.[1138] The objectives of the third goal in the SDG is to reduce global maternal mortality by 2030 to less than 70:100, 000 live births; to end preventable deaths of neonates and children up to age five (5) years old to 12:1,000 and 25:1,000 respectively; to end the epidemic of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne

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1135 Toebes *The right to health as a human right in international law* (Books for Civil Society Hart 2001) 6-7.

1136 https://www.researchgate.net/post/Can_anyone_explain_the_difference_between_Sustainable_Development_Goals_and_Millenium_Development_goals (Date of use: 2 June 2019).

1137 https://www.un.org/development/desa/disabilities/envision2030-goal3.html (Date of use: 20 May 2019).

1138 Resolution 70/1 of the UN General Assembly, the 2030 Agenda.

diseases and other communicable diseases; reduce premature mortality and mental health and wellbeing; and such like.

Of direct impact on the right to health is the objective to "achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all".[1139] The indices to measure the progress of the third SDG are: taking data per time to compare the decrease in mortality rates of under 5 year olds and neonates; collecting data to know the proportion of births attended by skilled health personnel; monitoring the incidence of HIV, tuberculosis, malaria, and hepatitis B infections; reduction of premature mortality from non-communicable diseases like cardiovascular diseases and suicide; coverage of treatment interventions for drug addiction and substance abuse; reduction of road traffic accidents; increase in the proportion of married women who have their needs for family planning met with modern methods; coverage of essential health services with tracer interventions; reduction of mortality rate from household or industrial pollution and unintentional poisoning; proportion of target population who are vaccinated; health worker density and population and capacity for emergency response amongst other indicators. These are measurable and quantifiable so that the concept of the goals does not merely exist in theory but has a realistic and practical approach to their achievement.

From the above, there is a dilemma. The SDGs are merely a universal call to action to improve lives but are not legally enforceable. The combination of unenforceable goals and unenforceable international patients' rights instruments (at least in Nigeria and South Africa), coupled with the failure of internal laws and institutions to protect the rights of patients has led to the need for an enforceable international instrument, whose enforcement institutions are not subject to national limitations, if patients' rights will be adequately protected. The question,

1139 https://unstats.un.org/sdgs/indicators/Global%20Indicator%20Framework%20after%20refinem_ent_Eng.pdf (Date of Use: 20 May 2019).

however, is what should be protected first, public health or private patients' rights? The next subsection attempts an expose on the dilemma.

7.4 Public health versus private protection

Public health is the science of protecting and improving the health of people and their communities. Some methods of implementing public health are education, policy making, research for diseases and injury prevention, promoting healthy lifestyles and detecting, preventing and responding to infectious diseases.[1140] Private protection on the other hand is concerned with case by case management of persons who access healthcare for various reasons. While the enjoyment of patients' rights may seem personal to each patient, patients are citizens, citizens make up the nation, and healthy citizens, make a healthy nation. Likewise, all policies, regulations and statutes are passed by humans and applicable to humans. Meanwhile, by nature the human body experiences wear and tear, not to add the accidents and sudden mishaps that may occur. It is pertinent to state that the workforce of most nations lies between the post-secondary school age and retirement ages of 15 years and 64 years.[1141] Within those years, even the healthiest citizen will need the hospital for one purpose or the other, for example, childbirth. It is therefore critical, that a nation that desires progress must prioritize the rights of its citizens when they access health services either for routine checks, or curative or terminal reasons. The downtime the labour force will experience each time a working citizen is ill will be reduced if the experience in the health facility is wholesome.

Although public health and patients' care are not the same in totality,[1142] one cannot be guaranteed without the other. For example, Patrick Sawyer, in resisting the idea of his restraint after his arrival in Nigeria, because he was infected with

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1140 It is important to include that defining public health is dependent on the professional thoughts of the definer and the purpose of the definition. See generally Albert S, "Careers in public health: what is the definition of public health? https://www.publichealth.pitt,edu/careers/what-is-public-health (Date of use: 18 November 2019); https://www.cdcfoundation.org/what-public-health (Date of use: 18 November 2019).

1141 https://data.oecd.org/pop/working-age-population.htm (Date of use: 18 November 2019).

1142 While public health is what is put in place to ensure the conditions for the people to be healthy are in place, patients' care relates to a case by case management of persons who access healthcare for various reasons.

the Ebola virus, pulled out his intravenous injection spraying Ebola ridden blood on the hospital staff and infecting them. By this one act, there was a start of an epidemic which was only averted by the quick action of the health team led by late Dr. Stella Adadevoh, who subsequently lost her life due to the infection.[1143] Therefore, if patients' rights are wrongly classified as affecting only patients, a poorly managed patient may wreak havoc on a society or even a nation. Inadvertently, there is no clear-cut line between the personalization of patients' rights and the assurance of public health. One is anchored on the other.

7.5 Codification of a "Global Patients' Rights Law"

Evident from the examination of the jurisdictions which form the focal point of this thesis, is the incommensurability of the patients' rights regime in all three jurisdictions. As already stated, the UK system on the protection of patients' rights appears to be the best of the three; that of South Africa being relatively fair and Nigeria's being poor. A combined reading of chapters three, four and five clearly show that while South Africa and the UK have specific enforceable patients' rights legislation or instruments, Nigeria's most recent effort at protecting patients' rights in the Patients' Bill of Rights is currently unexplored. This thesis recommends that patients should be protected beyond the general human rights provisions as in the Nigerian Constitution, as well as medical codes which do not have the same force as laws enacted by parliament. Also, while Nigeria and South Africa struggle with patients' rights enforcement, the UK's enforcement regime is considerably better even though it is not without its own challenges. As a natural consequence of the incommensurability of the patients' rights regime, healthcare standards – facilities, insurance and treatment or care, amongst others – are incommensurable too. Even with the international patients' rights regime discussed above, there exist major deficiencies.

The UDHR and the ICCPR for instance, are not just unenforceable (unless locally ratified) but vague in the context of patients' rights. The rights contained in both instruments are applicable to patients as "human beings" as opposed to patients as "users" of healthcare services; the latter should be the ideal because as

[1143] https://www.drasatrust.org/dr-adadevoh/ (Date of use: 13 May 2020).

discussed in several preceding junctures of this thesis, there are certain needs specific to patients as "users" that cannot be catered for by general rights.

The SDGs on the right to health, as lofty as its provisions for the development of the health sector on a global scale are, are merely a guide and not an enforceable directive.

The Declarations of Geneva, Venice and Lisbon, also unenforceable are not just "area specific" hence covering only specific patients' rights as opposed to the entire scope of patients' rights, but they are individualistic. All three declarations burden the practitioners, and in no way make provisions holding states accountable for the protection of patients' rights. At best, they have been adapted as medical codes in the focal jurisdictions which themselves, do not carry as much force as enacted legislation.

The European Charter of Patients' Rights and the European Convention on Human Rights, as progressive as they seem to be, only apply to the UK and other European countries.[1144] Thus, the other two jurisdictions considered in this research are automatically excluded from its coverage, falling within the realm of the African Charter on Human and Peoples Rights which again, is too general to cater for the specific right needs of patients as "users" of healthcare services.

This incommensurability requires that there be enacted, a "Global Patient's Right Law" and the importance is simple – human movement transcends borders, and it will be counterproductive to the inherent nature of human rights if an individual's enjoyment of his/her right as a patient is tied to his/her location or residency status in the country (s)he is receiving treatment in. The enactment of a "Global Patients' Rights Law" will thus, create a space where there is uniformity of standards for the protection of patients globally, reducing the need for medical tourism and limitations to proper treatment, care and respect for less privileged patients who cannot afford to travel to "better regulated" countries to seek standard health services.

[1144] Again, it is noteworthy that as of 31 January 2020, the UK ceased to be a member of the EU. The consequences with respect to EU adopted treaties are yet to fully unfold. BBC "Brexit: UK leaves the European Union" (2020) https://www.bbc.com/news/uk-politics-51333314 (Date of use: 1 February 2020).

The success of the “Global Patients’ Rights Law” will be tied to the functionality of its design, the nature of the rights provided for, the interaction between the law and the existing regional or national patients’ rights framework, and the scope of the law’s mandate to address systemic problems in global healthcare. This Global Law needs to have an enforcement mechanism without which it will merely exist in documents and not influence any improvement to the current situation.

The questions that naturally follow are: (a) what international body should enact the law? (b) what should be the scope of its provisions? and (c) what possible challenges might be encountered in the implementation of the law?

7.5.1 Enacting the Global Patients’ Rights Law

Because it is a “global” law as opposed to a national or regional law, the appropriate body from which such a law should emanate is the UN. The UN currently has one hundred and ninety-three (193) member states; while some of these member states may opt out of becoming signatories to the law, it is foreseeable that most will sign it if adopted by the General Assembly. The adopted law should be promoted by the WHO and justiciable at the International Court of Justice in the Hague in the Netherlands. The law should rest on the core global human rights instruments including the UDHR; the ICCPR; the ICESCR, as well as the 2030 Agenda for Sustainable Development. This law should represent a cooperative framework addressing patients’ rights in all its dimensions, cutting across borders and jurisdictions. It should foster international cooperation amongst all signatory states, acknowledging the need for commensurability in patients’ rights’ regulation globally, while upholding the sovereignty of states and their obligations under international law.

7.5.2 Proposed global patients’ rights law

The following paragraphs will outline certain provisions that the researcher believes ought to be included or reflected in the Global Patients Rights’ Law. These provisions are comprehensive and based on the provisions of extant patients’ rights regulations as previously discussed. Beyond this, the provisions take into consideration the gaps that exist in the patients’ rights regulations of the three jurisdictions under review.

7.5.2.1. Access to health services

a) Patients shall have the right to receive emergency health services free of charge, apart from certain limited exceptions sanctioned by the United Nations parliament or regional legislation. No country shall exclude citizens or visitors from emergency treatment except on grounds which have been found reasonable by a body separate from its highest legislative organ.
b) Patients shall have the right to access health services. Patients will not be refused access on unreasonable grounds.
c) Patients shall have the right to receive care and treatment that is appropriate for their health, meets their needs and reflects their preferences where it is affordable either as self-paying, insurance covered, or government funded patients.
d) Patients shall have the right to expect their regional government or healthcare bodies to assess the health requirements of their community and to commission and put in place the requisite services to meet those needs as considered necessary, and in the case of public health services commissioned by local authorities, to take steps to improve the health of the local community.
e) Patients have the right, in certain circumstances, to receive treatment in any country of domicile. The conditions attached to receiving treatment must not be discriminatory, exclude any person or group of persons based on their nationality.
f) Patients have the right not to be discriminated against in the provision of health services including on the grounds of nationality, gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity, marital or civil partnership status.
g) Patients shall have the right to access certain services approved by local, state or regional health bodies within maximum waiting times. Where the health provider cannot provide such service on non-discriminatory or reasonable grounds, it shall take all reasonable steps to offer the patient a range of suitable alternative providers. The waiting times in healthcare institutions shall be uniform or comparable to national and regional standards.

h) Health providers in nations shall commit to providing convenient, easy access to services within the waiting times set out in their laws; to make decisions in a clear way, so that patients and the public can understand how services are planned and delivered.
i) Healthcare providers shall make the transition of patient care as smooth as possible when patients are referred between services, and to put patients, their family and carers at the center of decisions that affect them. Patients' family and carers shall be a part of the treatment plan.
j) Patients shall have the right to access healthcare services, within and out of their country, and these rights include:
    i. right to receive timely emergency care at any healthcare facility that is open, regardless of patient's ability to pay for such emergency care.
    ii. treatment and rehabilitation made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof.
    iii. the right to provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, persons living with HIV or AIDS patients.
    iv. counselling without discrimination, intimidation or violence on matters such as reproductive health, cancer or HIV/AIDS.
    v. the right to palliative care that is affordable and effective for patients with cases of incurable or terminal illness.
    vi. a positive attitude displayed by healthcare providers that demonstrates courtesy, human dignity, patience, empathy and tolerance towards the patients in their care.
    vii. the right to health information that includes information on the availability of health services and how best to use such services, such information shall be in the language clearly stated and understood by the patient.
    viii. any other right that a patient is entitled to in the country where the patient is being treated.

7.5.2.2. Quality of care and environment

a) Patients shall have the right to be treated with a professional standard of care by appropriately qualified and experienced staff, in a suitably approved or registered healthcare facility that meets required levels of safety and quality services.
b) Patients shall have the right to be cared for in a clean, safe, secure and suitable environment of the healthcare facility.
c) Patients shall have the right to receive suitable and nutritious food and hydration to sustain good health and wellbeing while in care of the healthcare provider.
d) Patients shall have the right to expect regional governments or healthcare facility to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services provided.

7.5.2.3. Internationally approved treatments, drugs and programs

a) Patients shall have the right to drugs and treatments that have been recommended by the International Institute for Health and Care Excellence (hereafter “IHCE”), or any other relevant regional or national body responsible for the approval of drugs and treatments, for use in the administration of healthcare, if confirmed by doctor as clinically appropriate.
b) Patients shall have the right to expect international decisions on funding of other drugs and treatments to be made rationally following a proper consideration of the evidence provided by the relevant regional or national body responsible. If the local healthcare facility decides not to fund a drug or treatment needed by patients, adequate explanation of such decision should be made available to the patients and his/her doctor.
c) Patients shall have the right to receive the vaccinations that the International Joint Committee on Vaccination and Immunization recommends. This should be undertaken in a healthcare facility approved for the provided immunization program.
d) Patients shall have a right to screening programs as recommended by the International Screening Committee or any other body deemed as authoritative to so instruct by the WHO.

7.5.2.4. Respect, consent and confidentiality

a) Patients shall have the right to be treated with dignity and respect, in accordance with their human rights as provided for under various international and local laws.
b) Patients shall have the right to be protected from abuse and neglect. The care and treatment rendered by healthcare providers shall not be degrading to the patient.
c) Patients shall have the right to accept or refuse treatment that is offered to them, any physical examination or treatment shall be subject to the valid consent of the patient. If patient does not have the capacity give consent, it must be obtained from a person legally able to act on their behalf, and the treatment must be in the patients' best interests.
d) Patients shall have the right to be given information about the test and treatment options available to them, what the test and treatment involve and their risks and benefits.
e) Patients shall have the right and access to their own health records and to have any factual inaccuracies corrected. Patients' records belong to the patient and are only kept in the custody of the healthcare facility.
f) Patients shall have a right to privacy and confidentiality and to expect the healthcare provider to keep their private information safe and secure.
g) Patients shall have the right to be informed about how their information is used.
h) Patients shall have the right to request that their confidential information is not used beyond their personal care and treatment and to have their objections considered, and where their wishes cannot be followed, to be informed of the reasons including the legal basis.
i) The healthcare provider shall commit to ensure those involved in patient care and treatment have access to patient's health information to care for the patient safely and appropriately.
j) Healthcare providers shall ensure that if a patient is admitted to hospital, s(he) will not have to share sleeping accommodation with patients of the opposite sex.

k) Healthcare providers shall not share patient information except where they anonymize the information collected during the course of treatment and use it to support research and improve care for others subject to approval, and where identifiable information has to be used, to give the patient the chance to object wherever possible.
l) Patients shall have the right to be informed of research studies in which they may be eligible to participate. The patient shall be privileged to any communication sent amongst clinicians about patients' care.

7.5.2.5. Informed choice

a) Patients shall have the right to choose their healthcare practitioner, and to be accepted by that health facility unless there are reasonable grounds to refuse, in which case the patient will be informed of those reasons and such reasons shall be available in writing which may be subject to review.
b) Patients shall have the right to express a preference where it is reasonable and non-discriminatory for using a doctor or healthcare worker amongst the medical or health workers available. The expression of this right may however affect patients' right to applicable waiting times.
c) Patients shall have the right to transparent, accessible and comparable data on the quality of local healthcare providers, and on outcomes, as compared to others internationally.
d) Patients shall have the right to make choices about the services commissioned by health bodies and information to support these choices. The options of services available to patients should develop over time and depend on patients' individual needs. Details are to be set out in the handbook of the healthcare provider.
e) The healthcare provider shall commit to informing patients about the healthcare services available to them, locally and internationally; and to offer patients easily accessible, reliable and relevant information in a form they can understand, and support to use the services. This will enable patients to participate fully in their own healthcare decisions and to support them in making choices where the need arises. This will include information on the range and quality of clinical services where there is robust and accurate information available.

7.5.2.6. Involvement in patient healthcare

a) Patients shall have the right to be involved in planning and making decisions about their health and care with their care provider or providers, including end of life care, and to be given information and support to enable patients to do this. Where appropriate, this right includes their family and carers. This includes being given the chance to manage their own care and treatment, if appropriate.
b) Patients shall have the right to an open and transparent relationship with the health worker providing care. Patients must be informed about any safety incident relating to their care which in the opinion of a healthcare professional, has caused or could still cause significant harm or death. Patients must be given all the facts relating to their care and treatment, an apology where there is an omission of such facts and any reasonable support required for their wellbeing.
c) Patients shall have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by healthcare bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.
d) Patients shall have the right to transparent and unambiguous billing and a full disclosure of any cost including the cost of recommended treatment plans.
e) The healthcare provider shall commit to providing patients with the information and support needed to decide and analyze the planning and delivery of health services; to work in partnership with patients, patients' family, carers and representatives in the delivery of health services; to involve patients in discussions about planning their care, to offer a written record of what is agreed with patients and; to encourage and welcome comments on patients' health care experiences and use this to improve delivery of health services.

7.5.2.7. Complaint and redress

a) Patients shall have the right to make a formal written complaint against any healthcare provider for inadequate provision of healthcare services. Such complaint made about health services in any state of their residence shall be acknowledged within three working days and to have it properly investigated. This shall not put a patient at any risk of being refused treatment and shall not be a reasonable ground for refusal of treatment except patient has been found guilty of breaching patient responsibility.
b) Patients shall have the right to be part of the discussion of the way their complaint is to be handled, and to know the period within which the investigation is likely to be completed and the response thereto.
c) Patients shall have the right to be kept informed of the progress and to know the conclusion of any investigation into the complaint, including an explanation of the decisions and confirmation that any action needed to be taken in consequence of the complaint has been taken or is proposed to be taken.
d) Patients shall have the right to take their complaint to the International Health Service Ombudsman or National Government Ombudsman or its equivalent, if patient is not satisfied with the way their complaint has been dealt with by the health facility or professional self-regulatory organization of the state where the patient is being treated.
e) A patient shall have the right to make a claim for judicial review if s(he) thinks (s)he has been directly affected by an unlawful act or decision of a professional regulatory body, health monitoring body, ombudsman, local or international authority.
f) Patients shall have the right to compensation where they have been harmed by negligent treatment either as determined by a legally constituted professional disciplinary body or a court of law (either local or international).
g) The healthcare provider shall commit to ensuring that patients are treated with courtesy and receive appropriate support throughout the handling of a complaint. A patient's right to complaint shall not adversely affect future treatment; and when mistakes happen or if patients are harmed while receiving healthcare, patients shall receive an appropriate explanation and apology and where the need arises, compensation for such mistakes or

harm, apology delivered shall be done with sensitivity and recognition of the trauma the patients have experienced. Steps shall be taken by the healthcare provider to avoid the recurrence of a similar incident; and to ensure that the healthcare facilities learns lessons from complaints and claims and uses these to improve administration and delivery of health services.

7.5.2.8. Healthy and safe environment

Everyone shall have a right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal, as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection. The regional governments and health facilities shall adequately provide a healthy and safe environment for patients.

7.5.2.9. A second opinion

Patients shall have the right of request to be referred for a second opinion to a health provider of their choice where the need arises, and such request shall be attended to without delay.

7.5.2.10. Continuity of care

No patients shall be abandoned by a healthcare professional who or a health facility which initially took responsibility for the patient's health on any ground without appropriate referral or hand-over to another healthcare provider.

7.5.2.11. Visitation

Patients shall have the right to reasonable visitation in accordance with prevailing rules and regulations of the healthcare facility.

7.5.2.12. Responsibilities of the patient

a) To take care of his or her own health.
b) To care for and protect the environment, making it safe and healthy.
c) To respect the rights of other patients and healthcare providers.
d) To utilize the healthcare system properly and not to abuse it.

e) To know his or her local health services and the type of services offer.
f) To offer healthcare providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.
g) To inform the healthcare providers of his or her wishes regarding his or her death.
h) To comply with the prescribed treatment or rehabilitation procedures recommended by the healthcare provider.
i) To enquire about the related costs of treatment and/or rehabilitation and to plan for payment of such cost.
j) To take care of the health records in his or her possession for future reference.

7.5.3 Scope of provisions

The basis for a global law is to impose an obligation upon all governments to cater for the healthcare of all persons within their countries. The law should also fundamentally uphold the principles of fairness, equality and justice. This proposed law in its outline form is a reviewed version of the NHS Constitution with some additions from already existing international instruments which many nations and healthcare practitioners have already endorsed, such as the European Charter of Patients' Rights, the Declarations of Geneva, Venice and Lisbon as well as general and rights-specific regional instruments on patients' rights from continents other than Europe.

Some of the rights the law proposes include the right to access to health services; the right to quality of care and a clean environment; the right to nationally approved treatments, drugs and programs; the right to a healthy and safe environment; the right to participation in healthcare decision making; the right to insurance and medical schemes and knowledge of same; the right to respect, consent and confidentiality; the right to informed choice; the right to complaint and redress; the right to refuse treatment; the right to emergency treatment; the right to continuity of care, right to visitation amongst other rights that may be considered necessary. It is clearly stated, however, that these rights have as their bedrock, the core general human rights including the rights to life, dignity, religion,

free movement amongst others, as contained in the UDHR and other international human rights instruments.

Asides the rights provisions, the proposed global law ought to emphatically state the minimum standards expected of both public and private healthcare facilities in terms of facilities, staff qualifications, registration and licensing, staff training, amongst others. There is an obligation on governments to ensure a global minimum standard expected in terms of insurance. It is not enough for states to have nominal health insurance schemes, after all, Nigeria has one; the schemes must be seen to function to alleviate healthcare costs for citizens and visitors alike.

There is also a unique need of especially African states to be taken into consideration in the context of patients' rights – traditional medical practice. For the global law to really live up to its name, then such peculiarities must be provided for as patients who subscribe to traditional care and treatment are just as entitled to protection as those who subscribe to modern health facilities.

Another essential (if not the most essential) component of the global law must be its enforceability; sanctions provided for under the proposed law should be enforceable, this distinct feature is what will set it apart from previous general and patient-specific international patients' rights instruments. Beyond merely stating that the provisions of the law are binding and enforceable, it is imperative that measures for implementation and control are emplaced.

7.5.4 Implementation, monitoring and control

One of the major critiques of international human rights instruments is the fact that but for a few, they are usually unenforceable. It is for this reason that it has been argued that "international law cannot be considered law when applied to states or state action" but is merely a stabilizing factor in the international system – merely principles and decisions based on trust and goodwill. True law, it has been argued, must have a "true" obligation and enforcement beyond state consent or goodwill of the parties to the treaty.[1145]

[1145] Petallides CJ "International law reconsidered: Is international law actually law" 2012 IQ 1

If the global law must be effective, especially in developing states like Nigeria and South Africa, then there must be some mechanisms in place for implementation, monitoring and control.

Member states which opt to be signatories to the law should commit to its binding nature, as it is with the European Convention on Human Rights. For enforcement at national levels, the law should mandate domestication of its provisions, such that claims against individual doctors, private healthcare establishments or even the state can be filed in national courts on its authority. Economic incentives could be given for rapid domestication at the national level.

For state control, the importance of monitoring cannot be overemphasized. A special monitoring body should be created pursuant to the global law with the responsibility of, amongst other specific duties, maintaining up to date data on the progress of signatory states in enforcing the law. Sound data and analysis will not only help with monitoring at the international level but will enable state policy makers to identify the issues, design policy responses, implement and evaluate the necessary interventions.

The special monitoring body should have the *locus standi* to either on its own accord or based on a petition, after investigation, sue defaulting states at the International Court of Justice; the states can in turn within their sovereign jurisdictions, sanction defaulting healthcare facilities or agencies on whose account they were sued. In the alternative, the special monitoring body should have the jurisdiction to make recommendations to the UN to sanction defaulting states after proper investigations have been concluded. The possible applicable sanctions will depend upon conclusions reached after deliberations leading to the enactment of the law.

Emplaced mechanisms for monitoring and control must be very deliberate. Cues on other enforcement and control mechanisms can be taken from the recently enacted Global Compact on Safe, Orderly and Regular Migration 2018;[1146] although the Global Compact is based on “trust and goodwill” and not

[1146] Global Compact on Refugees, UN Doc. A/73/12 (2018); Global Compact for Safe, Orderly and Regular Migration, UN Doc. A/RES/73/195 (Dec. 19, 2018) (hereinafter “Migration Compact”).

enforceable, its provisions for enforcement and control, I believe, are a solid and an adoptable model:

1. The establishment of “a capacity-building mechanism” that supports efforts of signatory states to implement the global law by allowing the states, the UN and other relevant stakeholders in the healthcare sector including the private sector to voluntarily contribute technical, financial and human resources in order to strengthen capacities and foster multi-partner cooperation. The capacity-building mechanism will consist of:
   i. a connection hub that facilitates demand-driven, tailor-made and integrated solutions, by, for instance, advising on, assessing and processing country requests for the development of healthcare solutions.
   ii. a start-up fund for initial financing to realize project-oriented solutions.
   iii. an online open data source which serves as a repository of existing evidence, practices and initiatives and facilitates the accessibility to knowledge and sharing of solutions.[1147]
2. Cooperating and partnering with government agencies, practitioners, professional self-regulatory bodies, legal aids, civil societies, national and regional medical bodies, the private health sector, parliamentarians, national human rights institutions, academia, the media and other relevant stakeholders, for effective implementation.[1148]
3. Establishing a UN Patients’ Rights Network to be coordinated by the special monitoring body suggested above: the purpose of the network will be to ensure effective and coherent system-wide support to implementation, including the capacity-building mechanism, as well as follow-up and review of the law, in response to the needs of signatory states.[1149]

[1147] See Migration Compact article 43.
[1148] Migration Compact article 44.
[1149] Migration Compact article 45.

4. Mandating biennial reports to the UN General Assembly on the implementation progress, via the Patients' Rights Network.[1150]

Effective implementation will require concerted efforts at global, national and regional levels. Follow-up and review of progress should be made through a state-led approach with the participation of all stakeholders at national, regional and global levels.

Additionally, there must be a global sensitization across all media platforms, radio waves, cable television and digital media to inform the populace that their health should be given priority by themselves and by their governments. This sensitization may influence what citizens clamour for or the projection of elections in various countries. While these may seem as an encroachment on the sovereignty of these nations, the poor welfare of citizens in certain countries has led to massive exodus of persons into better systems through irregular migration. So, even when the global leaders avoid interference in the national issues of nations that fall short of best global practices, they will keep receiving irregular migrants who want to enjoy the enviable welfare schemes in these leaders' nations. Pursuing a global patients' rights' enforcement mechanism is one assured way to significantly reduce the ongoing irregular migration into the developed nations.

7.5.5 Challenges

As promising as the idea of a Global Patients' Rights Law is, it might be too optimistic to think that its enactment will not come with challenges. While this thesis focuses on only three jurisdictions — Nigeria, South Africa and the UK, the fact is that the Global law, if enacted, will be applicable to many more countries, with more diverse, complicated experiences. Some foreseeable challenges with implementation will include:

1. Cost for Governments: a major part of patients' rights provision and protection is cost. Rights like access to healthcare and right to quality care for instance, cannot exist where the state's healthcare system lacks up-to-date medical equipment and facilities for the protection of these rights, due

[1150] Migration Compact article 46.

to lack of funds – unfortunately, this is the situation in Nigeria and South Africa.[1151] The right to medical insurance can barely exist where a government cannot afford to provide same for all citizens and visitors alike. The implication of this is that financially resourceful states will be not just more likely, but also better equipped to adhere to the global law in respect of the provision of rights for which the funds must be available to make a reality. A possible means of generating funds could be adequately utilizing the tool of taxation – a tool which many developing countries seem to be struggling with. Taxation rates for legitimate work should include health insurance for each phase of tax payment; immigrants and visitors should be mandated to pay a sum for health insurance as is recently practiced in the UK. This can be adopted as the final stage in their visa and travel application procedures while irregular migrants, over stayers and asylum seekers may be permitted to access primary healthcare if they can show that they require asylum in the host country.

2. Corruption: unfortunately, many developing nations which happen to have the higher number of persons in need of better healthcare facilities, are largely riddled with political and economic corruption which will be inimical to the realization of the laudable goals of any global patients' rights' law, because implementing a health coverage plan for a nation requires consistent funding which may be diverted in the countries that need them the most. As stated in the preceding chapter, Nigeria for instance, has a unique problem of financial corruption in the public system, such that, even if there is a clamour for more funds to be directed to the health sector in the budget, there is no guarantee that the funds will be utilized for its primary purpose, or that it will be effected at the optimal level. It is worthy of mention that although the problem of corruption is more pronounced in Nigeria and other developing countries, it is not exclusive to them. The panacea might be a global enforcement mechanism which has a deterrent tool in place to ensure public office holders particularly in care of the health

1151 https://nigeriahealthwatch.com/gasping-for-air-doctors-death-exposes-inherent-risks-of-nigerian-public-hospitals/#.XVbspOhKjIU (Date of use: 16 August 2019).

value chain are accountable and ethical; petitions to the recommended special monitoring agency for instance, should suffice.

3. Implementation: The truth is that in the realm of international law, implementation is easier said than done because all states are considered sovereign. Naturally, conflicts might arise between the need to enforce the protection of the rights of patients and the need to respect the sovereignty of states. I suppose the resolution to that conflict lies in the theory that by voluntarily becoming signatory to a binding law as the Global Patients' Rights Law, states agree that their sovereignty with respect to the particular issue, is subject to their adherence to the provisions of the law.

It is pertinent to note that the challenges which may be encountered do not compare to the gains which will follow if the law is successfully adopted. For the human rights enshrined in international law to be enjoyed by patients irrespective of their location, there is the need for a global patients' rights law that guides all governments on their responsibilities to patients within their borders.

7.6 Conclusion

In this chapter, I have argued on the need for the enjoyment of a global best practices-standard of healthcare, everywhere around the globe. I have presented some International laws which if implemented would help safeguard the interest of patients without geographical limitations. This is because the global maximum healthcare standards can be replicated in most jurisdictions. I also attempted the determination of what the global maximum healthcare standards are, by considering the provisions of different international instruments on patients' rights. This led to the inexplicable conclusion that there are international laws and instruments projecting the obtainable minimum on a global standard, however bereft of the appropriate enforcement mechanisms. Only the UK with the European Charter on Patients' Rights and the 1949 European Convention on Human Rights, can boast of binding international instruments on the protection of patients' rights, and the mechanisms to enforce same. Also, I considered the sustainable development goals on the right to health and revealed that, although it is lofty and aimed at the development of the health sector on a global scale, it is merely a guide and not an enforceable directive. On whether the right in need

of protection is the public or the private health, to serve as a guide, I found that public health and private health are inseparable. What many patients' rights advocate is to protect both at the same time, and such is recommended based on my evaluation and assessments. I subsequently considered the need for a global patients' rights law, which I believe is paramount for enforcement and remedying breach, It is also recommended because these rights require external protection because of the weak state that patients find themselves in when they are sick, and a lot of us will be patients at least once in our lifetime or know at least one person who is a patient.

In conclusion, there are a lot of provisions for patients' rights in different legal documents. The observation is that two-thirds of the countries considered in this research have unenforceable international instruments and a failing national structure on the protection of patients' rights within their national borders. This underscores the need to bring all these together and harness these various laudable international instruments to an enforcement machinery, the global patients' right law. As mentioned above, if citizens are at the mercy of the public office holders, it will be unfair for them not to have recourse to other avenues to table their grievances or access a global status healthcare. There should be global support for all humans to enjoy the highest attainable standard of health irrespective of their ancestry or location. The same way, the global leaders come together when there is a threat to the peace of the world, the enjoyment of patients' rights should fuel a united front for its enforcement. Where capital resources are lacking grants should be given to stabilize the health sector.

CHAPTER 8: CONCLUSION AND RECOMMENDATIONS

8.1 Introduction

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, nationality, religion, political belief, economic or social condition.[1152]

The fulcrum of this research is that although patients' rights are subsumed under general human rights, the importance of patients' rights necessitates its protection and its global recognition as a distinct right. In a bid to better appraise patients' rights and the need for the intervention of a Global Patients' Right Law, I examined patients' rights protection in South Africa, Nigeria and the UK. Although laws exist that promote or protect patients' rights in the countries, as well as soft laws and international charters, patients' rights are still being abused, either as a result of an uninformed society, or because the enforcement mechanism for the infringement of patients' rights is not strong enough or favours the healthcare worker. The research therefore sought to examine the various laws and structures in existence in these countries on patients' rights protection, and to determine whether they are enough to protect patients' right in the target countries.

I argued in chapter two above that all human rights are applicable to patients as they are humans. However, their status as patients further creates an obligation on caregivers to actively employ patients' rights. I argued that the development of human rights has impacted on the evolution of patients' rights extensively. This is because almost all identifiable human rights are directly or indirectly intertwined with patients' rights. There is an increased awareness and demand for distinct rights of patients, thus necessitating the creation of separate and distinct documents for the protection of the patient. I also argued that the realization of a patient's rights is not only tied to the patient's awareness of said rights, but also to the level of a patient's rights awareness of caregivers, guardians and medical workers. I concluded in chapter two that the attention given to human rights and

[1152] Preamble to the WMA.

its violations across the globe, must also be given to patients' rights. I argued, likewise, that the issues plaguing the actualization of patients' rights are precarious and may not be resolved easily as there is no one-size-fits-all solution. I therefore emphasized the need for a basic enforceable minimum standard to serve as a global yardstick in upholding patients' rights.

In chapter three, I examined legislative instruments on the protection of patients' rights in Nigeria. I found these to be inadequate because the prevailing institutional, social and technical flaws in the Nigerian public service have watered down the enforcement of these laws. I acknowledged the federal government's efforts to regulate patients' rights by the making of the Patients' Bill of Rights. I however noted that the fact that this instrument lacks the force of law constitutes a significant deficiency, as there is no promise of enforcement. Since the Patients' Bill of Rights was announced in 2018, there have been no tangible or significant changes to the enforcement of patients' rights in Nigeria to prove its efficacy.

In chapter four, I examined the instruments and institutions for the protection of patients' rights in South Africa. South Africa has innovative adoptions to secure patients' rights, including the regulation of traditional medicine. However, just as it is obtainable in Nigeria, the realization of the rights, the enforcement, protection and remedying of infringements are major challenges in South Africa. I concluded therefore that these limitations place a responsibility on government agencies, legal aid councils, and professional self-regulatory bodies if a patient right conscious South Africa is to be achieved.

Patients' rights in the UK were examined in chapter five. The practices in the protection of patients' rights in the UK extend also to receptionists, telephone operators or other non-medical personnel linked to the health service provision. The institutions and laws in the UK were found to be patient friendly, even though they are not without their own limitations. I concluded that the UK can be an example to be emulated in other jurisdictions considered in this research.

In chapter six, I attempted a comparison of all three jurisdictions, to determine what gives each jurisdiction an edge that can be emulated by other jurisdictions. I found that the choice of a country's system of government can affect the level and cost of healthcare services available to patients. Although the three countries

are commonwealth nations, I found a wide dissimilarity in healthcare practices in each country. These include the protection of patients' rights of traditional healers in South Africa, which is non-existent in Nigeria and the UK; institutional insurance which is not common in Nigeria compared to South Africa and the UK; the no fault compensation scheme in the UK; institutional protection of patients' rights which is more reliable in the UK than in Nigeria and South Africa; non-litigation approaches to the resolution of medical claims which are more pronounced in the UK and South Africa, as against the practise in Nigeria; and the Unitary System of Government in the UK aided all round development of medical institutions as against what is obtainable in the Federal Republic of Nigeria and South Africa. Likewise, The UK gives credible information on disciplinary decisions on a regular basis. South Africa through the HPCSA does the same, but the records are not satisfactorily detailed. Nigeria does not publish any record of professional discipline. I applauded the UK for the systems put in place to regulate the health service sector and ensuring that their delivery is always on point, over and above what is obtainable in South Africa and Nigeria. I concluded in this chapter that NHS Constitution is a good example of patients' rights protection that can be adopted in the codification of a Global Patients' Rights Law.

In chapter seven, I argued on the need for the enjoyment of a global best practices-standard of healthcare which can be replicated and/or adopted in other jurisdictions. I also attempted to determine global maximum healthcare by considering the provisions of different international instruments on patients' rights. This led to the conclusion that although there are international laws and instruments projecting the obtainable minimum on a global standard, they are either too general, too specific or bereft of the appropriate enforcement mechanisms. Only the UK with the European Charter on Patients' Rights and the 1949 European Convention on Human Rights, can boast of binding international instruments on the protection of patients' rights, and the mechanisms to enforce same.

The question therefore is: is there a connection between national development of the health sector and the binding nature of international instruments? These two

factors are present in the UK, and they are not replicated in Nigeria and South Africa in enviable proportions. I therefore proposed the need for a binding international instrument, or at least one which has strong enforcement and control mechanisms in place -- a Global Patients' Rights Law. There should be global support for all humans to enjoy the highest attainable standard of health irrespective of their ancestry or location.

8.2 Concluding Remarks

The countries within the scope of this thesis are in three different categories in patients' rights protection. If there is an imaginary ranking scale based on the laws, enforcement and existing data, the UK is the closest to the ideal. But not without its myriad challenges which include, but are not limited to, increased cases of medical malpractice, infringement of the rights to privacy, the rights of the mentally ill,[1153] privatization of the NHS and healthcare system as well as Britain's exit from the EU. South Africa is in a distant second with poverty, crime and the slow implementation of the National Health Insurance Scheme. Then Nigeria is last in this comparative analysis on most measuring indices. Though Nigeria has laws to protect the patients, the lack of a reliable law enforcement system, large number of citizens living below the poverty line and a failing healthcare system amid corruption, means that patients' rights take a distant back seat.

This research is distinct from previous attempts at researching patients' rights as it is one of the very few attempts to consider the protection of patients' rights in recent years. It is also the pioneering research in comparing patients' rights in the three jurisdictions. It evaluates laws, policy and court decisions relating to patients' rights in each jurisdiction, determining their adequacy. Although there have existed international health laws and patient treaties, this work proposes a model patients' rights law to be adopted by the UN, promoted by the WHO and justiciable at the International Criminal Court, Hague, Netherlands; there is no other body of work which has considered this proposition. The law should be

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1153 Davidson, *An examination of the rights of the mentally disordered in English law in the context of articles 3 and 5(i) of the European convention of human rights and fundamental freedoms*, (PhD thesis University of Cambridge United Kingdom 2004) 88.

ratified by UN member states to protect patients all over the world and underscore the importance of protecting the rights of patients.

This thesis consulted soft laws, Acts of parliament of the various countries within the scope of the research and professional regulations intended to protect the patient. There are numerous conflicting opinions on some of the rights of patients, especially on the right to emergency medical treatment, limits of autonomy, consent and confidentiality. Yet, there is a seeming agreement on the existence of patients' rights and a favourable alignment to the supposition of this thesis, that patients' rights are a distinct form of rights which are meant to be specially protected, considering the subservient and vulnerable circumstances that patients often find themselves in.

The scope of patients' rights covers a wide range of expanding rights from life, to confidentiality, consent, a right to dignity, refusal of treatment, a right to a hospital bed while on admission, among others. Patients' rights are applicable to all persons including children[1154] and those who lack capacity. Laws have been created to protect patients from the infringement of these rights and the courts must do more for the patients.[1155] This is because there are a lot of cases of patients' rights infringement[1156] and insufficient remedying of these rights. Patients' rights can be abused by doctors, nurses, pharmacists, laboratory staff,

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1154 See for example abuse of patient and child in Senosi M "Newborn's arm broken in hospital" https://www.dailysun.co.za/News/National/newborns-arm-broken-in-hospital-20180304? (Date of use: 16 August 2019). In this report, the 21-year old mother alleged that the doctor broke the arm of her newborn and was told he had apologized, a claim which she refuted. The question arises as to whether an apology would be enough relief for breaking the arm of an infant by a doctor.

1155 CBC News obtained the annual report filed by the Canadian Medical Protective Association from 1901 and analysed the past forty years, concluding that winning malpractice suits was a near impossible task. Between 2013-2017 of the forty years analysed, 55.2% of cases were dismissed, discontinued or abandoned; 36.7% of the cases were settled; 6.5% of the cases were determined in favour of the doctor and 1.6% in favour of the patient. A very miniscule percentage of 1.6% shows the patient has an uphill task and explains some reluctance on the part of a lot of patients Nosheen H and Culbert A "As fewer patients sue their doctor, the rate of winning malpractice suits is dropping too" https://www.cbc.ca/news/health/medical-malpractice-doctors-lawsuits-canada-1.4913960? (Date of use: 16 August 2019).

1156 See Arora A "Indian surgeon operates on leg of patient hospitalised for head injury" https://www.sbs.com.au/language/english/indian-surgeon-operates-on-leg-of-patient-hospitalised-for-head-injury (Date of use: 16 August 2019). See also report of wrong site, wrong surgery in Kenya, Merab E "Horror at HNH as doctors open skull of wrong patient" https://www.nation.co.ke/news/KNH-doctors-perform-surgery-on-wrong-patient/1056-4325292-iyudmvz/index.html (Date of use: 16 August 2019).

hospital records staff and other healthcare practitioners. This research is not an attempt at attacking a profession, neither is it an accusation of dereliction. Rather, it is a holistic approach to the protection of patients' rights from all spheres. Each patient must be treated as an individual with rights, considering other factors such as health resources, other patients, and limitations in medicine but not using these factors as excuses to disregard patients' rights.

Despite the publicized cases of patients' rights infringement in various countries and continents, health practitioners have retained a relative level of trust. Patients who have had a relationship of obedience to their practitioners are finding it difficult to oppose paternalism. This infers that the balance of power in trust and healthcare settings tilts in the favour of health practitioners. The law is the tool which patients expect will be used in their defence when the healthcare practitioner abuses their rights, but the law is limited as medicine, and technological developments have always been faster than legal development. Patients' rights laws, where they are enforced, have been discovered to build the confidence of the patient and boost the doctor-patient relationship.

Enforcement of patients' rights which are congruent to the right to health is feasible and practicable if the governments of nations commit to healthcare provision and regulation. It becomes more feasible if international bodies and organizations make it important, as nations would rather not be left behind with international development. The countries within the scope of this research, South Africa, Nigeria and the UK have lessons to learn from one another with Nigeria and South Africa being the biggest learners. The provision of law, enforcement of laws and a health system that puts patients first will protect patients' rights without much ado. The UN and regional bodies like the AU, the European Union and the Commonwealth must also act as a dog that can bark and bite by monitoring and sanctioning countries that do not sufficiently protect the rights of a patient. The SDG on health is easily achievable with a patients' rights focused health system. The attainment of this goal will improve the economy,[1157] growth and development of any nation, protecting its workforce and preserving its young.

[1157] 1.2 billion pounds was paid to about 7000 patients in the UK in 2017 as compensation for medical claim. This amount could have been used to improve the health system if these errors are minimized by patients' rights protection measures. See Slawson N "NHS

A patients' rights centred, and conscious healthcare system will aid to the enjoyment of the highest attainable standard of health.

8.3 Recommendations

8.3.1 Model Global Patients' Rights Law

There is a need to protect patients for the humans they are. Human rights are protected in international law and so should patients' rights. In fact, there is a crucial need to protect patients' rights, as patients are often weak, in an acquiescent position and unable to make important decisions. This justifies the argument for a model global patients' rights law protecting the patient in international law. The basis for this is rooted in the fact that governments might make laws and in turn break them,[1158] agencies of government including healthcare institutions, private health establishments as well as individuals in health services, might disobey laws and evade the consequences. Courts might also rely on technicalities to deny citizens of their patients' rights or outrightly interpret laws to suit paternalistic opinions of health workers. This can be negated by a universally accepted framework of what patients' rights are, how they should be protected and the appropriate punishment for persons who infringe on these rights, not excluding those who aid and abet.

A possible argument against a global patients' rights law is that one law cannot suffice for the whole world and the phrase that "the world is a global village" is only true to some extent. The antagonism to this idea may appear valid. However, international laws and treaties are part of the why the world is one piece. The fear of international sanctions, excommunication from the group of nations and trade barriers mean that nations would rather act in unison when there are uniform rules than act independently even when it is inconvenient. Another possible criticism of this recommendation is the difficulty of adopting, domesticating and

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Compensation "unsustainable" https://www.theguardian.com/society/2018/feb/02/nhs-compensation-payouts-unsustainable-say-health-leaders (Date of use: 12 August 2019).

1158 See *Odafe and Others v Attorney-General and Others* (2004) AHRLR 205 (NgHC 2004) where the court relied on Article 16 of African Charter on Human and People's Rights and provisions of the Nigerian Constitution, to ensure the Nigerian government does not discriminate against HIV/AIDS patients who were also awaiting trial in a Nigerian prison https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/03/Odafe-Others-v-AG-Others_Nigeria_2004.pdf (Date of use: 12 August 2019).

enforcing international laws. Although these are valid challenges and should be considered, international human rights instruments and criminal courts, especially war crimes courts and the fear of them, have shown the world that a united front can keep the world in check.

8.3.2 Domestication of existing International laws

The precursor to the model "Global Patients' Rights Law" is the adoption of existing local, national, regional and international patient protection related laws. This will empower patients and protect them from abuse and rights infringement. It will also encourage the demand for the enforcement of these rights beyond national and regional boundaries, putting laws to test and ensuring perpetual patients' rights abusers are brought to reckoning.

Beyond domestication, however, states must commit to ensuring the progressive realization of these laws because domestication really means little or nothing if there are no signs of even the least effort being put into their implementation. As we have seen earlier, this problem of implementation has often been the case with Nigeria and South Africa. Domestication must be supported by effective implementation.

8.3.3 Local, national, and regional laws

The existence of laws at the global stage can make nations and all who subscribe to the international treaties tow in line but a more acceptable way of integrating a patients' rights culture might be the adoption of local patient friendly laws in local governments, counties, townships and provinces. This will make the communities own the laws and become conscious of its infringement or protection. Nations can also promulgate laws for the protection of patients' rights or review and convert existing soft law to have the force of law with punishments for infringement and not being open to subjective interpretation. In the course of the adoption of a Global Patients' Rights Law, regional bodies like the ECOWAS, South African Development Community, European Union, AU and other similar bodies can adopt uniform patients' right laws like their proposed economic framework. If it is proposed and can be adopted for the economy, it can be considered for healthcare and patients' rights especially.

8.3.4 Hospital Patients' Rights Charter

One of the most popular patients' rights documents across the world is the American Hospital Association Patients' Bill of Rights. Although this is from a professional body, it shows how groups, organizations and healthcare institutions can make deliberate attempts to protect the rights of patients.

Legislative force aside, healthcare providers owe ethical and moral duties to their patients. The Hippocratic Oath partly states, "I will not be ashamed to say, I know not, nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery. I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death… will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm".[1159] Thus, regardless of the presence or absence of state regulation, it is the ethical thing to do for practitioners and health facilities alike to consciously take measures of their own volition to protect the rights of patients.

The existence and promotion of patients' rights charters made available to the public and responsive reporting systems will propagate the patients' rights idea. Each hospital and healthcare provider should show in a visible place, the hospital policy on the rights of patients; this is already in existence in some healthcare facilities, but it must also include the possible sanctions for an attempt to breach the rights of the patient. An argument that this may lead to defensive medicine cannot supersede the need for protection of the patient and reassurance of his/her rights.

8.3.5 Special courts for patients' rights infringements

The creation of specialized courts is usually proposed for several dedicated issues, such as family issues, children, war, corruption or human rights violations, among others. This same devotion should be accorded patients' right cases. The reason for this is the speed and technicality required of some medical and patients' rights decisions. In some cases, for example, a patient's refusal of

[1159] https://www.britannica.com/topic/Hippocratic-oath (Date of use: 26 June 2019).

medical treatment might require a judicial affirmation, and this must be done in a short period. The allocation of special courts and judges will make this an easier task. Particularly the appointment of judges and judicial officers with some medical knowledge will improve legal decisions in healthcare settings. This intersection between medicine and law is a technical one and requires some familiarity and specialized knowledge.

The time that it takes for patients across the world to get compensation or relief, after their rights have been infringed upon is saddening. This time factor is not limited to any country or region although some countries seemingly have faster systems, but cases across board show a similar pattern in judicial delay leading to injustice and worsening the effect of the abuse. In the fall of 2012 Kacho, a 74-year-old woman went to a pain clinic and had an injection for the pain in her back by an anaesthesiologist, which led to meningitis. The doctor had an untreated staph infection and this patient was only one of the people who he made sick as a result. His license was revoked for ten months, but the patient is still in a battle for compensation after seven years.[1160] This shows that the practitioner had returned to work just ten months after and the patient is left with the task of getting some justice almost a decade later.

The procedure in legal matters sometimes restricts patients from getting their rights enforced.[1161] Courts of law must jettison procedure and stick with attaining justice and protecting patients even where the procedure is not perfect. A deliberate attempt at sticking with rules might put the patient at risk as the doctor-patient relationship is unequal. The law must be seen to be on the side of the downtrodden and protective of the rights of the patients despite gaps in procedure. In Nigeria and many other African countries, delays in court processes have become a norm, discouraging citizens from instituting claims to enforce their rights. The problem with these delays becomes even more magnified when one considers that many patients' rights infringement cases are likely to be time-

1160 Nosheen H and Culbert A "As fewer patients sue their doctor, the rate of winning malpractice suits is dropping too" https://www.cbc.ca/news/health/medical-malpractice-doctors-lawsuits-canada-1.4913960? (Date of use: 16 August 2019).

1161 In *R v. Akerele* a medical practitioner applied overdose of Sobita on some children which led to their death. The West African Court of Appeal held that the doctor was criminally negligent and convicted him for manslaughter. This decision was, however, upturned by the Privy Council on appeal based on technical grounds.

sensitive; by the time judgments are delivered on certain cases, the patients in question might be dead, or harm already done might be irreversible

8.3.6 Technological innovations in solving medico-legal dilemmas

Patients' rights deal with medicine and medical innovations are usually ahead of the law. The law is in a constant race to meet developments in science and technology. There is, however, a need to include technology in solving patients' rights dilemmas. Although some jurisdictions have adopted judgements via live video callings, conference calls for arriving at best interest decisions, this is not very popular especially in South Africa and Nigeria. The speed with which decisions must be made in patients' related cases sometimes is not feasible in many jurisdictions considering the bureaucracy and tedious process of litigation and professional discipline.

An example is the decision on whether a patient who might die should be allowed to uphold their right to refuse medical treatment. A decision of this nature cannot be delayed due to filing processes, appointment of a judge to oversee the matter etc. Filing via email, delivering judgements via video conference calls and general use of technology to support existing redress platforms, might aid swift and beneficial court decisions in support of patients' rights. It is on record that a few decisions of courts have become mere academic experiences because events overtook the issues before the court.

Camera footages have helped to uncover some of the worst forms of patients' rights abuse. There could be a debate about the effect of such innovations on patient privacy, but where patients consent, these may unravel some mysteries in negligence and patients' rights abuse cases.[1162] In an alleged case of rape by a doctor on his patient, the victim and her husband undertook a sting operation and recorded the doctor as proof of an infringement by the practitioner which

1162 Triggle N "Whorlton Hall: Hospital 'abused' vulnerable adults" https://www.bbc.co.uk/news/health-48367071 (Date of use: 16 August 2019) where abuse of patients was revealed by an undercover reporter and Gloria Esegbona (on behalf of the estate of Christiana Esegbona, deceased) and King's College Hospital NHS Foundation Trust [2019] EWHC 77 (QB) where claimant and defendant were not certain as to how the tube of patient was removed although the court resolved that patient must have either struggled to pick something or the tube was removed in error. A footage of the hospital room with consent of patients or carers would have sorted the impasse.

might have been difficult to prove. The recording is not a foolproof guarantee of justice for the patient, however, it gives the patient something to hold on to in his/her case.[1163]

8.3.7 Patient centred decisions and departure from paternalism

Ethical guidance for healthcare professionals must direct that they avoid paternalistic decision making, no matter how good intentioned. Patient-centrism must be policy driven and ethically imbued in the professional guidelines periodically released to ensure that professionals have a uniform guide on addressing issues. To protect and promote patients' rights, decision making in healthcare settings must be patient centred and not influenced or manipulated by the health practitioner's personal views and opinions.[1164] The ethical dialogue on autonomy must be reemphasized by courts, professional disciplinary bodies and patients' rights advocates. The dialogue underscores the importance of patients as individuals who can make their own decisions despite the seeming irrationality or unacceptability of the decisions to the healthcare practitioner.[1165]

In a British Medical Journal opinion, a series was initiated to encourage patient participation. The title was "What is your patient thinking" and the series identified themes like insensitive language and poor communication between the practitioner and the patient, and the failure of the doctor to see the patient as a whole person.[1166] This buttresses the point that patient involvement in care

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1163 Jafar J "Exclusive: How doctor sedated, raped married woman in Sokoto" https://dailynigerian.com/exclusive-how-doctor-sedated-raped-married-patient-in-sokoto/ (Date of use: 16 August 2019).

1164 Flanigan J "Refusal rights, law and medical paternalism in Turkey" 2013 *Journal of Medical Ethics* 636-637.

1165 Sherwood H "'They are together, they are equal': the agonizing choice facing father of conjoined twins" https://www.theguardian.com/society/2019/aug/04/separation-conjoined-twins-dilemma (Date of use: 5 August 2019). In this report Ibrahim Ndiaye has refused the separation of his conjoined twins' daughters Marieme and Ndeye. The separation could give Ndeye a chance of a reasonable life but Marieme would not survive the separation. This is similar to the case Gracie and Rosie Attard (anonymized as Mary and Jodie during the case) Re A (Conjoined twins) [2001] 2WLR 480, where the court r ruled that the separation should take place against the wish of the patients saving Gracie and allowing Rosie to die. The practitioners at Great Ormond Hospital, London have h however accepted Ibrahim's decisions and are not challenging his decision to leave his two children without a separation which could in turn lead to the death of the twins.

1166 Cartwright E and Macdonald H "What patients think and how they have changed our practice" https://blogs.bmj.com/bmj/2019/05/10/emma-cartwright-and-helen-macdonald-what-patients-think-and-how-they-have-changed-our-practice/ (Date of use: 16 August 2019).

cannot be overemphasized as it is a *sine qua non* for the realization of patients' right. To keep patients away from decisions that affect them, not minding the good intentions, will only push the patient further from the actualization of his/her rights.

8.3.8 Curriculum development and training of healthcare workers on patients' rights

An untrained and uninformed healthcare worker will find it difficult to uphold the rights of patients. Based on statistical analysis, health practitioners in some countries are aware of most of the rights of patients, however they are also either totally unaware or less informed about some germane rights of the patients.[1167] This suggests that patients' rights must be introduced in the curriculum for the training of a wider spectrum of healthcare workers.[1168] There is some form of legal and ethical training for doctors and nurses who are in contact with patients, patients' records and healthcare in general must it be designed for the protection of patients' rights.[1169] A compulsory inclusion in the curriculum will make it inexcusable for practitioners to deny patients of their rights.

Healthcare workers requiring training in this context should, as it is in the UK, extend beyond medical practitioners to administrative workers in healthcare facilities. While training of practitioners should be in university, training of administrative staff should be the responsibility of the healthcare facility employing them.

8.3.9 Revalidation of healthcare workers

Revalidation is a process of ensuring a doctor remains fit to practice at a time subsequent to his registration as a medical practitioner.[1170] There has been a continuous debate over the direct effect of revalidating health workers. The debate is centred on whether revalidation would lead to improved healthcare

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1167 Pascal Iloh *et al* 2017 *BLDE Univ J Health Sci* 100. In this research 87.3% of doctors had positive attitude to patients' rights with 100% of participating doctors knowing of the right to confidentiality. 54% however were not aware that the patient had a right to know the identity and professional status of the physician.

1168 An earlier study in Nigeria and India had shown that 86% and 69.2% of doctors felt their knowledge of medical ethics was inadequate. See Fadare *et al* 2012 *Niger Med J* 228.

1169 See Woogara J "Patients' Rights to Privacy and Dignity in the NHS" 2005 *Nursing Standard* 35-36; where the scholar argued that special areas like privacy and dignity must be included in the curricula of students in healthcare training.

1170 See Brazier and Cave *Medicine Patients and the Law* 12.

services. This research advocates for revalidation as a means of protecting patients' rights. This is different from continuous professional development events which lead to points for annual registration. Revalidation will ensure that health professionals who are not current with treatment procedures and health practices will either be unlicensed or retrained. It may form part of the process for determining who needs which continuous professional development program and who has not attended any. This will in turn protect the rights of patients especially their right to access quality healthcare.

In addition, revalidation may serve as a gatekeeping mechanism for health professions as healthcare providers who have been disciplined and struck off or suspended from the registers would not remain in practice. Where there is no periodic requirement for revalidation or re-registration and with the large nature of countries used in the research among other nations, health practitioners who are supposed to be serving a disciplinary term might move from one location to another and continue to practice due to loopholes in the monitoring systems. A few cases of continued attempt at practicing while suspended exists in some jurisdictions and in others where it is not on record, it is believed to still be a prevalent occurrence. The cost of revalidating all medical and healthcare workers periodically might be high but this cost cannot be compared to the unnecessary loss of lives occasioned by unethical practice.

8.3.10 Professional disciplinary bodies should be proactive with "mystery shopping"

Mystery shopping is a method used to monitor and measure quality of service and customer experience in retail. It is sometimes used by companies to assess their internal workings. The mystery shopper can be an individual or a corporate organization. This thesis recommends that hospitals, health facilities, government agencies and professional ethical bodies, in charge of healthcare should engage "mystery patients" to determine whether their staff are upholding patients' rights. The advantage of mystery shopping, albeit a patient as a tool for measuring patients' rights infringement and protection, is that the mystery shopper is not a "real" patient, hence the proactiveness of the decision.

While many healthcare facilities may boast of excellent reporting systems, only few have active measuring systems to prevent the incidents of patients' rights abuse. Adoption of a mystery shopping mechanism will expose the gaps and gaffes in the healthcare system. This would keep practitioners on their toes, importantly where such mystery shopping outcomes are conducted by professional ethical bodies and can be used as justification for discipline. This system may also be used to identify areas needing improvement and quality from patient perspectives which will be given by the mystery participant.

The BBC panorama had an undercover member of staff work at a hospital in Whorlton Hall, County Durham, UK for two months only to discover the abuse of vulnerable patients at the facility. The staff members at the hospital confessed unknowingly to use of unnecessary force, were caught on camera mocking and restraining patients without such need. The patients concerned were persons with learning disabilities and autism. As a result of this undercover report, sixteen staff were suspended and all patients at the facility were transferred to other facilities. This came two years after the CQC had rated this facility and reported it as good.[1171] This is not the only case they have uncovered as they also uncovered a similar situation in 2011 where the reporter spent five weeks undercover and recorded the slapping, taunting, and general abuse of some of the hospital's most vulnerable patients. Some were showered fully clothed and pinned down as a form of punishment. The report also led to the change of facilities for patients and the arrest of four healthcare workers. The interesting dimension to this case is that the tip-off for the undercover recording was from a former nurse at the hospital who had initially reported to the hospital management and the CQC, but nothing was done about the nurse's report.[1172]

8.3.11 Penalties for breach should be in the public domain

Professional ethical bodies and courts have given decisions in cases of patients' rights infringement which are mere slaps on the wrist. This may erode patient confidence in reporting systems. This thesis therefore recommends

1171 Triggle N "Whorlton Hall: Hospital 'abused' vulnerable adults" https://www.bbc.co.uk/news/health-48367071 (Date of use: 16 August 2019).

1172 https://www.bbc.co.uk/news/uk-13548222 (Date of use: 16 August 2019).

commensurate punishments for breach of patients' rights, exemplary damages and judgements which will serve as deterrence for others. The reports of professional disciplinary bodies should also be made public like the Fitness to Practice Panels of the GMC UK, and the *ratio decidendi* for the decision must be given. In South Africa, though the offence and punishment are made public, the reasoning is not published. This gives room for queries where seemingly similar cases have extremely differing judgements. The Nigerian Medical and Dental Practitioners Tribunal has not released reports of its disciplinary cases to the public in over three decades, as only matters which are appealed or contested get to the public. In one of the few reports by a newspaper on a disciplinary case by the Tribunal, it was held that a doctor who had severed the lower limb of a baby in error, after erroneously certifying the child dead, should be suspended for six months, and another doctor who was "preferred with two charges of professional negligence" was to be suspended for six months as well.[1173] The danger in decisions of this nature is that there is no stated ratio for the decision and there are no details to justify the length of the suspension periods. General terms like "charge of professional negligence" only make patients wary of demanding for their rights. Decisions like this also embolden healthcare practitioners who know that the worst punishment that may be meted out on them is a six months suspension after which they will be able to return to their practice.

In the UK, although there were about four hundred and fifty-six lives shortened by the actions of Dr Jane Barton at Gosport War Memorial Hospital, she was not erased from the medical register and there were no prosecutions; she chose to retire instead. Other officials who were involved have also not been asked to answer in any court or tribunal.[1174] Cases of this magnitude without commensurate punishment clog the wheel of patients' rights protection and limit the patients' zest for justice. In another case, a senior psychiatrist, Dr Valerie Murphy was suspended for twelve months as lead clinician who treated Connor Sparrowhawk who died at eighteen years of age, under her care at Slade House Oxford. She admitted to her failure to see warning signs and allowing him to go

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1173 Sahara Reporters "Doctor suspended; others await verdict as medical council probes unethical practices" http://saharareporters.com/2019/04/28/doctor-suspended-others-await-verdict-medical-council-probes-unethical-practices (Date of use: 16 August 2019).

1174 https://www.bbc.co.uk/news/uk-england-44547788 (Date of use: 16 August 2019).

into the bath alone despite having two epileptic seizures in the preceding week. Grippingly, the psychiatrist's suspension did not deter her from working in Cork, Ireland where she was registered with the Irish Medical Council and worked at the time of the decision.[1175] The decision was another slap on the wrist in the unending battle to affirm patients' rights protection. The courts across jurisdictions should look circumspectly at decisions of professional bodies and give appropriate sanctions for public confidence and protection of patients' rights.[1176]

8.3.12 Patients' rights enlightenment policy to be inclusive and to reach the masses

To achieve the protection and promotion of patients' rights there must be some patient enlightenment backed up with policy. An advantage of the policy is that it will guarantee that the enlightenment program is guided and inclusive. A patients' rights enlightenment policy should be established, which will propagate and publicize existing patients' rights laws on all media. The television stations, radio stations and print media should be adopted to inform citizens of their rights and how they can get reprieve when those rights are abused. This policy must also ensure that the promotion of patients' rights must be done in the local languages and dialects of the citizenry, especially in heterogeneous communities. This enlightenment policy should also be in audio, braille and all accessible formats for persons living with disabilities.

The internet can also be utilized, not just for enlightenment, but for feedback. In Egypt, for instance, there is also an online initiative which aims to raise knowledge

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1175 Halliday J "Psychiatrist suspended for 12 months after man drowned in epileptic fit" https://www.theguardian.com/society/2018/feb/21/psychiatrist-suspended-12-months-connor-sparrowhawk-death (Date of use: 16 August 2019).

1176 An example of such is in the Bawa Garba case where the High court upturned a 12 month suspension of the doctor and declared that she be erased from the register. *Hadiza Bawa-Garba v The General Medical Council* [2018] EWCA Civ 1879. Also Dyer C "Paediatrician convicted of manslaughter must be erased from register, rules High Court" https://www.bmj.com/content/360/bmj.k417.full (Date of use: 16 August 2019).

about patient awareness through an interactive voting online survey[1177] for Egyptian patients to share their opinions about their rights.[1178]

Ensuring that the rights of patients are protected requires more than educating policy makers and health providers; it requires educating citizens about what they should expect from their governments and their healthcare providers - about the kind of treatment and respect they are owed. Citizens, then, can have an important part to play in elevating the standard of care when their own expectations of that care are raised. When patients are aware of their rights, they can demand for them and speak out about them.[1179]

8.3.13 Advanced directives policies for patient decisions

The advantage of advanced directives for patients' rights is that it reduces the need for alternative decisions of medical practitioners or family members where the patient lacks capacity. A lot of patients' rights infringement are recorded where the patient is incapacitated and cannot make a medical decision. Patients who are of legal age and capacity should be able to make advanced directives for themselves, while parents or guardians can make advanced directives for patients below the legal age of majority.

The "advanced directives" policy is not a term strange to medical practice. It is actually already a practice in some European Union member states including the UK, as well as other states including the USA, Spain, Portugal, Argentina, Uruguay, Belgium, Holland, Mexico, and Brazil.[1180] Notably, none of the listed countries where it is practiced is African.

1177 Patient's Right Charter http://Eseed.net/project/egyptianpatient/ (Date of use: 29 November 2015).

1178 The website <egyptianpatient.org> is fully responsive platform with mobile view, it can serve as a tech sample for patients' rights engagement and improvement.

1179 WHO, "Patients' rights" https://www.who.int/genomics/public/patientrights/en/ (Date of use: 27 January 2020).

1180 Silvana Cogo and Valeria Lunardi, "Advance Directives: A Documentary Analysis in the Global Context" http://www.scielo.br/scielo.php?pid=S0104070720180003003 00&script=sci_arttext&tlng=en (Date of use: 29 January 2020).

The institutionalization of advanced directives as part of patient protection policies will allow patients to preserve their autonomy even though they do not have the ability to make medical decisions.

8.3.14 Alternative dispute resolutions as a solution to patients' rights infringements

Alternative Dispute Resolution (hereafter "ADR") techniques should be adopted in solving patients' rights complaints to enhance speed and make it less cantankerous. These may include mediation, conciliation or arbitration. The office of the Ombudsman in the Healthcare Society Professionals Association and the Health Ombud in South Africa among other examples, suggests that some countries are making a shift from the argumentative resolution of patients' concerns and adopting swift, solution-based approaches to rights enforcement and compensation of patients.[1181] Many studies show not only that ADR methods such as early apology, mediation or arbitration are very rational from an economic perspective for the healthcare providers, but also that these techniques improve the patients', or their relatives', satisfaction.[1182]

Adopting a non-court-based approach also allows openness in investigation results for alleged patients' rights infringements. The fear of losing a practice license, pushing colleagues "under the bus", and ruining camaraderie might be eradicated if practitioners are aware that most patients want closure, justice, compensation and relief. A non-litigation approach may ease this.

The ADR solution might not be appropriate, however, in situations where the alleged infringement on patients' rights involve elements of crime; for instance, where a patient dies due to the negligence of the health practitioner and the state decides to prosecute the practitioner for murder or manslaughter.

1181 See Durojaye E and Agaba DK "Contribution of the Health Ombud to Accountability: The Life Esidimeni Tragedy in South Africa" 2018 *Health Hum Rights* 164-166.

1182 Petr Šustek and Tomáš Holčapek "Alternative Dispute Resolution in Medical Malpractice Disputes" https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3213596 (Date of use: 27 January 2017).

8.3.15 Compulsory professional indemnity for compensation

One of the solutions to patients' rights infringement is the compulsory subscription to professional indemnity by health professionals.[1183] In countries like Nigeria and some other developing countries, many professionals are not professionally insured. The effect of this to patients is that whilst the court or professional bodies might grant some relief, damages, fines or compensation, it might be impossible for the practitioner to fulfil this obligation because of affordability. This keeps the patient in limbo. If the professional is, however, compulsorily indemnified, his/her insurers will be obliged to pay damages. The doctor, nurse or medical laboratory worker will therefore be conscious of his/her possible skyrocketing insurance premium if (s)he abuses patients' rights and the patient is assured full payment if (s)he gets financial compensation from courts or arbitration awards.

8.3.16 Accessible National Health Insurance Schemes and universal healthcare specially to include emergency treatment

The right to emergency medical treatment is one that places a lot of pressure on the healthcare practitioner. The cost of maintaining the hospitals, especially privately-owned clinics, often rests on a single person, the owner. There have been cases highlighted in this thesis where patients were detained for their inability to pay their hospital bills.[1184] In some other cases, patients were being sued to pay the cost of their treatment. The solution to this is making national health insurance schemes accessible and affordable. The net spread of persons covered in the insurance schemes of Nigeria and South Africa is relatively low and this calls for concern. An insured society can promote the right of patients to emergency medical care without fear of incurring cost to the practitioner.

1183 See for example the Canadian medical protective association which covers liability for health practitioners and legal support, Boyce DE "Supporting members in a changing healthcare environment" https://www.cmpa-acpm.ca/en/advice-publications/cmpa-perspective/2019/ message-from-the-cmpa-president (Date of use: 16 August 2019).

1184 *Millicent Awuor Omuya alias Maimuna Awuor & Another v. The Attorney General & 4 Others* (2015), Petition No. 562 of 2012 Kenya, High Court, Constitutional and Human Rights Division. See also Yates R, Brookes T and Whitaker E "Hospital Detentions for Non-payment of Fees A Denial of Rights and Dignity" https://www.chathamhouse.org/sites/default/files/publications/research/2017-12-06-hospital-detentions-non-payment-yates-brookes-whitaker.pdf (Date of use: 13 August 2019).

Governments must also make primary healthcare accessible for pregnant women, children, orphans and vulnerable people.

The challenge with this recommendation is that as stated in the previous chapter, many developing countries can barely afford to provide up-to-date medical facilities, talk less of subsidizing health costs for millions of citizens. The reason for this incapacity is two-fold: deficiencies with revenue generation systems; and corruption and theft of public funds. It is the responsibility of the government to formulate revenue generating mechanisms in order to cover health insurance costs. A better tax system is suggested for Nigeria, South Africa and other developing countries.

8.3.17 Patients' rights advocates, pro-bono cases and legal aid for patient support

Individuals, groups and organizations must join the advocacy for and protection of the rights of patients. Patients' rights advocacy is more popular in America than in most jurisdictions but must be encouraged around the world. The same way there are human rights activists, environmental rights advocates and other defenders of rights in various spheres, there must be an increase in the number of persons willing to advocate for patients to prevent them from infringement and to provide recourse for breach where it occurs. Donor bodies should create categories of grants for patients' rights advocates as it is the case for other aspects of human rights.

Legal practitioners in developing countries are encouraged to take *pro bono* cases as part of their community service and may be made a mandatory requirement for attainment of senior membership of the bar. These *pro bono* cases must include those which provide solutions and damages for patients' rights infringements.

8.3.18 Improved and transparent complaint and reporting systems (with deadlines for feedback and action timelines and room for appeals and reviews)

This research recommends an improved complaint and reporting system at health facilities around the world and in the countries within the scope of this research. It is believed that one of the ways to protect patients' rights is to have

patient feedback and reports from patients on how they were treated and where they feel that their rights have been infringed upon, as well as a procedure for redress. A lot of hospitals and health facilities do not have accessible complaint and reporting systems. Some have moribund complaint boxes in obscure locations, others ask that you report to the person at the desk, whereas in some cases, the person at the desk is the abuser. Some have non-functioning numbers and email addresses which make the reporting system futile and remedy for patients' rights tedious or impossible. The reporting system of health facilities must be open and accessible, as anonymous as possible until there is a need to take up the case, it must build the confidence of the patient in the system and be independent. This will promote patients' rights and protect the patient from further abuse of rights and from the denial of the right to make complaints or get recourse.

8.3.19 Inclusivity, equality and diversity friendly access to healthcare

Holistic patients' rights must be engaged to include engineering of healthcare facilities, buildings, disability friendly spaces and improved inclusion policies. A lot of places where patients are expected to receive care are not inclusive. Buildings must be thoroughly planned to ensure accessibility especially for persons living with disabilities. This suggests that patients' rights are not limited to doctors, nurses or healthcare workers. Engineers, builders, architects, town planners and everyone in the construction industry must be included in the policy development for patient friendly spaces. There must also be sanctions for professionals whose decisions actively deny or restrict patients' access to healthcare hence infringing on their rights.

The global increase of unjustifiable racial and tribal discrimination across the world means patients may be denied their rights based on where they come from, the language they speak, their accent or the pigmentation of their skin. To overcome this, healthcare workers and facilities must be open to diversity. This includes the provision of interpreters for patients, to get informed consent before medical procedures. Reportedly some health facilities officiously make patients endorse procedures, including those who do not understand the language of communication or the procedure. The language options for health leaflets should

also be provided so that language will not be an impeding factor limiting patients from enjoying their rights as patients.

Income, race, culture, colour, language, religion, gender, political opinion and education among other determinants must not be used to discriminate against patients. A patients' income bracket should not deter him/her from being able to access healthcare. Health services must make deliberate policies to reduce and possibly eradicate obvious processes that may be deemed discriminatory and ensure equal opportunities for all patients.

Professional ethical bodies in healthcare must emulate the GMC and give ethical guidelines on managing patients with some form of special needs, including learning disabilities. Patients are at the centre of healthcare services and should be protected across jurisdictions.

8.4 Final thoughts

I have argued for universal patients' rights. I have said what I believe would make a difference. I conclude with two quotes, the one from an American physician and the other from a Canadian physician:

> Civil and political rights are critical but often not the real problem for the destitute sick. My patients in Haiti can now vote but they can't get medical care or clean water[1185]

> The good physician treats the disease.
> The great physician treats the patient who has the disease[1186]

If more healthcare workers embodied the above worldview the patient will become the centre of healthcare. I believe the case for patients' rights has been properly made. I have proposed a roadmap to achieving implementation of patients' rights across the globe However, I recognise that the path to liberation and victory shall not be smooth. I charge those who have the power to make

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1185 https://www.nytimes.com/2003/03/29/arts/q-a-health-care-for-the-poorest-as-a-central-human-right.html (Date of use: 1 May 2020).

1186 William Osler quoted in Centor RM "To be a great physician, you must understand the whole story" 2007 *MedGenMed* 59.

decisions, to deem patients' rights an issue worthy of immediate consideration. That governments and international non-governmental organisations commence the process of addressing the obvious gap in global regulation and enforcement of patients' rights. This work has come at an auspicious moment, during a pandemic when there are more people who have become patients and where there is a focus on healthcare and rights. I hope the times will shift the focus on patients even when the Corona Virus disease[1187] pandemic is over.

Most of us have either been or will be patients. Our rights should matter.

[1187] https://www.who.int/health-topics/coronavirus (Date of use: 1 May 2020).

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