

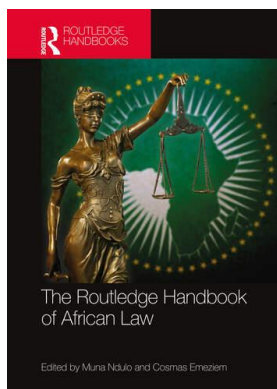
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Ernest Owusu-Dapaa

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COMMISSIONS OF INQUIRY AND THE QUEST FOR A GREATER ACCOUNTABILITY IN HEALTH CARE DELIVERY IN AFRICA

A Ghanaian perspective

Ernest Owusu-Dapaa

Introduction

Accountability is a value that is widely approved and revered. The obvious rationale for universal acclaim for this value or concept is that it safeguards the rights and liberties of those who are subject to the exercise of power by those to whom accountability is being demanded. A closely related benefit of accountability is transparency. In the situation of power relations, such as the doctor–patient relationship, accountability is compellingly important. Indeed, the disequilibrium of power between the obviously vulnerable patient and health care professionals requires that a mechanism be deployed that would ensure that the powerful parties in such relationships are made aware of the checks on the exercise of their power. The necessity for subjecting the otherwise untrammelled power of the health care professional over patient to scrutiny was underscored by the shocking revelations of the Nuremberg Trials in the aftermath of the Second World War. Indeed, the Nuremberg Trials drew the world’s attention to the atrocities perpetrated by physicians and scientists under the guise of National Socialism, and also, in the purported interests of medical and scientific progress.¹ The Nuremberg Declaration of 1947 on human experimentation is largely attributable to the public judicial inquiry held after the war. Important regulatory frameworks governing medical practice and other crucial aspects of medicine also emerged in the United Kingdom after public inquiries into medical scandals (Miola 2007, Chs. 1 and 8).

The last three decades witnessed a dramatic metamorphosis of most African countries, including Ghana, into democratic states. With respect to political governance, significant milestones have been attained, but the quest for accountability should not be confined to the metapolitical sphere. Health care delivery, in Ghana and many other African countries, being an area bedeviled by the exploitation of vulnerable patients by health care professionals who seem

to defy accountability to even their own patients, is in urgent need to expose abuse of medical power and unearth other factors that militate against patients' empowerment. This chapter explores the prospects of deploying the constitutional mechanism of holding public inquiries to bring abuses and scandals in health care delivery into the light for a public discourse to be developed around the virtual lack of accountability in this sphere of African society. Beyond exposing lack of accountability by health care professionals in African developing countries like Ghana, the public inquiry could be a catalyst for enactment of legislative or policy norms to govern other novel aspects of medical practice that are unregulated.

In the next section, the chapter presents a narrative of the bleak situation of patient safety in Ghana by citing concrete instances of patient abuse and exploitation of patient vulnerability. Next, the chapter explores the vexed issue of demonstrable disconnect between the prescriptions of the law and the realities on the ground as far as health care accountability is concerned. The chapter locates a potential panacea on the horizon by interrogating the prospects of the constitutional mechanism of commission of an inquiry in advancing the quest for greater accountability in health care delivery in Ghana. The chapter concludes by underscoring the fact that accountability is really at a lower threshold in the current state of health care delivery in Ghana. The power to commission a public inquiry under the 1992 Constitution could be activated to bring to fore the myriad cases of patient abuse and exploitation.

Burgeoning incidence of patient abuse and exploitation in Ghana

The phenomena of patient abuse is not new in Africa, particularly, in Ghana. However, the last decade has witnessed an increasing incidence of unmitigated and flagrant violations of patients' rights. In order to explore indicators of patient vulnerability in Ghana, it is apposite to offer a working understanding of the phrase "patient vulnerability" in this context.

Patient vulnerability has been explained as "an inability of patients to retain control of their life situation or to protect themselves against risks/threats to their integrity" (Irurita 1999, 11). Kennedy aptly explained patient vulnerability, noting:

As between the doctor and the patient there is an inevitable imbalance or disequilibrium of power. The doctor has information and skill which the patient, who lacks these, wishes to employ for his benefit. When it is remembered that among the powers possessed by the doctor is the privilege to touch and even invade the body of another and as a consequence exercise control to a greater or lesser extent over that person, it will be clear that with the best will in the world, and conceding the good faith of the doctors, such powers must be subject to control and scrutiny, from an abundance of caution.

Kennedy 1988, 387

Of course, every patient would like his or her doctor not only to be competent but more importantly, to put the patient's interest over and above that of the doctor's. The importance of this desire among patients cannot be overemphasized. As Mehlman helpfully noted, it is important to the patient for three good reasons:

First, you have far less power than the doctor ... if you are sick you will need care urgently, you are not in a good position to insist upon seeing the most highly qualified and trustworthy physician. Second, the doctor often has to do things that you cannot monitor because you are untutored or oblivious. Third, your health and

well-being are in peril, and most likely you are worried and afraid. Some experts say you can be so intensely affected by your circumstances that you are no longer the same person.

Mehlman 2006, 1139

It is imperative to note that patient vulnerability is not an abstract construct or mere rhetoric in relation to the health care experiences of patients; it manifests itself in medical malpractice and gross violations of patients' rights. I thus proceed to survey some of the reported incidence of medical malpractice and violation of patients' rights that manifest explicit or tacit exploitation of patient vulnerability. The illustrations are largely drawn from judicial decisions, media archives, and academic literature.

First, there are few judicial decisions that are relevant to the issue of the exploitation of patient vulnerability. Thus, the purpose of citing some of these decisions here, again, is not necessarily to explain what was decided in those cases, or to suggest that the existence of just a few judicial decisions indicates that the exploitation of patient vulnerability only occurs infrequently, but to offer real case examples that graphically illuminate patient vulnerability. To begin, in *Darko v. Korle-bu Teaching Hospital*,² instead of the right knee being operated on, the team of surgeons in the leading teaching hospital in Ghana operated on the left knee of a patient. The hospital refused to further attend to the patient, as a protest against a medical negligence suit that the patient had initiated against them. Clearly, the decision of the hospital to refuse further treatment when the patient sued them can reasonably be attributed to the obvious imbalance of power in the doctor–patient relationship. Indeed, the posture of the hospital seems to suggest that, insofar as a patient had consented to the doctors treating him, he did not have any right whatsoever to challenge an act or omission by them, to say nothing of dragging them to court for redress.

Moreover, in the case of *Elizabeth Vaah v. Lister Hospital and Fertility Centre*,³ (hereafter, *Vaah*) court action was required before medical records were released. For our present purposes, it is evident from *Vaah* that a patient is helplessly vulnerable in their clinical experience unless the law intervenes to guarantee certain safeguards. A reasonable inference from the decision of the hospital not to disclose medical records to an aggrieved patient is ostensibly to conceal alleged malpractices perpetrated against the patient.

Another illustration of the exploitation of patient vulnerability may be found in *Somi v. Tema General Hospital*, where a 36-year old pregnant woman was rushed to hospital with an antepartum hemorrhage. The doctor on night duty had finished earlier than expected at 4.00am instead of 8.00am, and the morning doctor on day duty did not report until 10.00am. The nurses tried to keep the patient alive, but they could not hear the heartbeat of the unborn child. The patient was finally taken to the operating theater after an inordinate delay. Neither the mother nor the baby survived the operation.⁴ Significantly, this case reveals a glaring lack of respect for a patient's right to receive reasonably prompt care at a health institution in an emergency case. Indeed, if there was a vibrant culture of consciousness of patient rights among health care professionals, it would be more likely that the necessary accountability mechanism would have been put in place by the defendant hospital to check the lateness of the doctors, in order to avert a recurrence of this incident.

Furthermore, in *The State v. Kweku Nkyi*, a student nurse at the Kumasi Central Hospital was asked to treat a sick child. He injected the sick child twice with what he believed was the medication mepacrine. The child's condition immediately deteriorated, and he died within a few hours. A postmortem examination revealed that the death of the sick child was caused by arsenic poisoning.⁵ It is reasonable to infer here that the case of allowing a student nurse to treat

a child, without supervision by a properly qualified health care professional, is symptomatic of the vulnerability of patients in Ghana.

As noted previously, the paucity of judicial decisions does not necessarily imply that medical malpractice and scandals relating to patient vulnerability do not occur in the Ghanaian health care system in appreciable proportions. To the contrary, the reality is that only a few aggrieved patients are able to pursue redress in court, or even in a supposedly less cumbersome quasi-judicial forum like the Commission for Human Rights and Administrative Justice (CHRAJ). Abject poverty, coupled with ignorance and illiteracy, confronting many patients in Ghana is another layer of complexity regarding patient vulnerability. To construct a fuller picture of the stark reality of patient vulnerability in Ghana, it is appropriate to survey some of the many stories in the media concerning medical malpractice and scandals.

The media in Ghana is replete with numerous stories of medical malpractice, which ultimately result from either deliberate or unintended exploitation of patients' vulnerability in the country. Notable examples will be cited here to buttress the claim made earlier that Ghana's health care is bedeviled with numerous incidents of medical malpractice that do not find their way into courts or other quasi-judicial fora such as CHRAJ.

Recently, a leading doctor noted that over 50 cases of medical negligence involving fatalities are recorded in various hospitals every year in Ghana, but none of them is ever dealt with (Tsatro 2018). This revelation was made when a doctor was commenting on a well-publicized story of a toddler who died in a local hospital after a doctor had switched off the oxygen mask due to the parents' inability to pay for it. Also, *The Insight*, a Ghanaian newspaper, reported that a patient had died from complications arising from gauze that a doctor had negligently left in the belly of the patient after surgery. This was revealed by another doctor who had desperately tried to save the life of the patient, but pleaded anonymity. The newspaper reported that it had compiled tens of such cases across the country, to be published in the future, and revealed that, "[s]ome members of the Ghana Medical Association (GMA) who spoke to *The Insight* on the case of medical negligence want action to stop the malpractices" (*Insight Reporter* 2014).

Another shocking example is a report featured in *The Mirror* under the headline, "Doctors Render Woman Barren ... After Leaving Towel in Her Abdomen" (*Mirror Reporter* 2012). The report stated:

A 26-year-old woman who went for a caesarean section at the Brong Ahafo regional hospital in Sunyani is furious at the medical team that took the operation for a tactless act that nearly cost her life and has left her barren because the team left an operation towel in her abdomen.

Ms. Ernestina Adade Konadu went through the ordeal two years ago when she went to the hospital to deliver.

Consequently, the woman, whose first attempt resulted in this disastrous manner, is demanding GHC150,000 as compensation from the hospital.

The botched caesarean section, in the process of which Ms. Konadu lost her baby, after which she went home with another complication, took place on October 7, 2010.

Ms. Konadu endured severe abdominal pains for over a year before diagnosis at a different health facility ... revealed that the pains she had been experiencing was the result of an object lodged in her abdomen.

A subsequent operation to remove the object revealed an operation towel which had been left in her abdomen after the caesarean section a year earlier.

According to her medical report, the operation to remove the towel rendered the victim barren, meaning that she could no longer conceive and bear children.

Moreover, her medical condition has so deteriorated that she can no longer engage in any hard work.

After investigations into the matter, the authorities of the Brong Ahafo Regional Hospital confirmed and recognized the incidence of negligence on the part of the medical team but said the hospital was not in a position to pay compensation to Ms. Konadu.

Ms. Konadu has, therefore, appealed to the Minister of Health, all relevant statutory bodies and the coalition of non-governmental organizations on human rights issues to step in to ensure that the right thing is done to save other patients from suffering similar fate.

According to her, the Brong Ahafo Regional Chief State Attorney, Madam Afia Serwaa, who is also counsel for the Brong Ahafo Regional Hospital, had warned her to back down on her demand or she (Madam Serwaa) would go public with Ms. Konadu's medical condition. [Emphasis added].

The media report raises pertinent issues that represent some of the layers of complexity concerning patient vulnerability in Ghana. First of all, the narrative suggests that the hospital medical team, who were guilty of serious medical negligence, had exploited the vulnerability of the patient. Another plausible inference is that either proper records of the surgical procedure were not completed, or the doctors failed to carry out a proper post-surgery review of the patient. As Edwin has aptly noted: “By not disclosing a medical error, the doctor conspicuously places his own interests above that of the patient to the detriment of the patient, thereby violating a patient-centered ethic” (Edwin 2009, 34). Beyond the gross abuse of the rights of the patient by the doctors, the official government lawyer responsible for advising the hospital exacerbated the already pathetic situation of the vulnerable patient by threatening that if the patient did not abandon her grievance, she would risk having her medical condition made public. It is submitted that, regardless of the nature or degree of sensitivity of her medical condition, if the allegation by the patient is true, then it is telling evidence of patient abuse and the exploitation of her vulnerability in Ghana.

Another example of the numerous media reports of medical malpractice in Ghana is a story broadcast on a radio station concerning the death of twin babies during delivery. Earlier scans taken during the patient's antenatal days had indicated she needed a Caesarean section delivery, but nurses at the hospital on that day forced her to deliver vaginally. Realizing she could not stand the pain, she began crying, upon which a doctor advised she should have the Caesarean section. However, there was no anesthetist available during the surgery. The patient alleged that the death of both twins was due to the absence of an anesthetist while she was being prepared for the operation (*Joy Online* 2010).

Related to the foregoing instances of malpractice is the manifestation of a culture where transparency is lacking in medical practice in Ghana, especially with respect to errors and mishaps in medical operations. A significant example of this point is the reaction of the doctors at the Komfo Anokye Teaching Hospital (KATH), the second leading tertiary hospital in Ghana, toward allegations of a number of patient deaths due to the breakdown of life support machines in the hospital's Intensive Care Unit. Addressing a press conference in response to the death of six patients following the breakdown of the ventilators at KATH, Dr. Baffour-Awuah, the medical director, stated: “It is medically unethical to reveal the number of patients who have died as result of the broken down ventilators.’ He continued, ‘with or without ventilators, patients die at the hospital.’” (Tawiah 2012).

Two important points are worth noting from the foregoing quotation. In the first place, it is confirmation that some of the medical advances that prolong the lives of patients in some of Ghana's health facilities are being utilized. Second, it indicates that even for the limited number of life support machines available in Ghanaian hospitals, there appears to be a lack of an adequate accountability framework to safeguard patients. Notably, for the first time since its establishment in 2010, the media reported that:

The Korle Bu Teaching Hospital (KBTH) has established information and complaints desks at the various out patients departments (OPDs) to afford clients and patients the opportunity to seek redress for their grievances instead of going to the media.

In addition, the hospital is to form a Clinical Ethics and Professional Committee to address the concerns and grievances of patients and clients.

At a media briefing in Accra last Friday, the Chief Administrator of the hospital, Professor Nii Otu, said the committee would comprise experienced medical and para-medical professionals, religious leaders and individuals from other interest groups.

He said such a committee would help the hospital to step up its drive to improve quality health care, adding that "the core duty of the committee would be to address grievances of patients and clients bordering on our services."

Yeboah 2010

The press statement from KATH raises further concerns over the absence of a properly conceptualized legal framework to promote and protect patients' rights, while clearly clarifying the responsibilities of health care professionals. Indeed, the fact that it was only in 2010 that a major hospital like KATH initiated measures to address some of these concerns—at least according to the best available archival evidence—is quite suggestive of how bleak the situation is for the entire country, particularly with respect to non-tertiary health institutions there.

The phenomenon of the exploitation of patient vulnerability, as revealed in the plethora of examples given in this chapter, has far-ranging ramifications that impinge on the quality of health care and the degree of patients' trust in the system. I now turn to these possible ramifications. From the foregoing illustrations, it can be discerned that health care providers tend to disregard requests for information by patients or challenges from them. Such attitudes of health care professionals could be symptomatic of a culture of excessive medical paternalism. There are certain statutes and some case law that deal with issues arising in the doctor-patient relationship and in some other contexts of health care delivery in Ghana. Although some of the existing legislation addresses health care in perfunctory manner, it is true that other factors like cultural and social attitudes relating to health care professionals are partly responsible for disempowerment of patients in Ghana. It was against this backdrop that the Ghana Health Service (GHS) adopted the Patient's Charter in 2002, a statement of patients' rights. The main aim was "promoting an open and positive relationship between and amongst health workers and patients" (Owusu-Dapaa 2016, 152; GHS [2002] 2017b). Despite the adoption of the Patient's Charter, the phenomenon of patient disempowerment persists in Ghana, as previously noted. This reinforces the position, taken earlier, that the creation of a body of health care law (HCL) per se is not an immediate solution to the conundrum of patient disempowerment.

The apparent lack of awareness of the Patient Charter and the fact that it appears to be disregarded by health care professionals was further amplified by a serious debate that took place in 2011 (almost a decade after the adoption of the Patient Charter) on a popular radio station, Joy FM, between two leading members of the medical profession in Ghana over whether or

not there exists a mandatory duty for a doctor to explain the side effects of a prescribed drug. Arguing against the existence of a duty of risk disclosure, Dr. Frank Serebour, the Vice President of the Ghana Medical Association (GMA) at the time, insisted that there were no written laws or regulations binding doctors to explain the side effects of drugs they administered to their patients. In opposition, Dr. Jehu Appiah said that it was ethically mandatory for doctors to ensure that patients were made aware of the implications of the drugs administered to them before they were allowed to use them. This debate suggests that there is a certain cultural or social attitude underlying how Ghanaian doctors view their duties in relationship to patients. Any progress toward patient empowerment would ultimately necessitate addressing these cultural or social factors (Owusu-Dapaa 2016).

It may be surmised that the doubtful legal status of the Patient Charter might partially account for the virtual lack of awareness and noncompliance with those rights and responsibilities. Although such an argument can only be pressed so far, it is notable that the situation could radically improve, because the Charter has now been invested with full statutory status due to the recent passing of the Public Health Act, 2012 (Act 851). It remains to be seen whether merely formally legalizing the Charter will enhance awareness and compliance and possibly generate more enforcement action in the form of litigation. However, it is important to point out that the content of the Charter is not sufficiently empowering from the patient's perspective, as the provisions are predominantly hortatory. This contrasts sharply with the framing of human rights and fundamental freedoms in the 1992 Constitution and other rights leading to enactments. Unlike the homiletic tenor of the Patient Charter, the usual legislative drafting tradition in Ghana regarding the enshrining of rights is to use an imperative modality of "shall."⁶ In that way, the obligation of the relevant duty bearer vis-à-vis the particular right is made more emphatic and subject to judicial enforcement action. Moreover, the Charter does not provide any administrative body in the form of a patients' ombudsman or equivalent agency for the monitoring or securing of compliance with the Charter, in addition to any court enforcement actions available to those who may opt for the arduous route of litigation.

Health care accountability—A regulatory failure or disconnect between legislation and realities of health care

A critical factor for ensuring healthcare accountability is the enactment and enforcement of regulatory legislation. In this section, I explore the extent to which this crucial component of health care accountability exists in Ghana. To some extent, there are many statutes that have been enacted in Ghana to govern various aspects of health in general and health care in particular. In Table 1, I outline these statutes and note their implications for health care in terms of patient empowerment.

From Table 1, it is clear that there is no specific or dedicated legislation dealing with the various issues arising from medical advances, such as in vitro fertilization (IVF)-assisted reproduction or organ transplantation, which have gradually been imported into health care in Ghana. In addition to this obvious gap in Ghanaian law, the theme of patient empowerment has not been featured prominently in health care legislation enacted in Ghana from the colonial era to the post-independence era. The situation, which has existed since the inception of this research in 2011, has now improved with the recent enactment of the Mental Health Act, 2012 (MHA) and the Public Health Act, 2012 (PHA). Admittedly, the MHA has made a significant shift in putting the issue of patient empowerment or patients' rights at the center of the legal and policy framework for mental health. Specifically, the Act provides a compendium of rights for mental patients. To begin with, it affirms the importance of the self-determination of voluntary

Table 12.1 Health care-related legislation in Ghana

Short title of statute/Delegated legislation/ Guidelines	Relevance to the empowerment of the patient and the regulation of medical advances
Health Professions Regulatory Bodies Act 2013 (Act 857)	<ul style="list-style-type: none"> • Consolidates the existing statutes on the Medical and Dental Council, Pharmacy Council, and Nursing and Midwifery Council into one statute. • Creates two new regulatory bodies—the Allied Health Professions Council and the Psychology Council.
Public Health Act 2012 (Act 851)	<ul style="list-style-type: none"> • Provides for a comprehensive legal framework for public health. • Incorporates the GHS Patient’s Charter as a compendium of patient rights. • Repeals the old disparate statutes on public health—the Infectious Diseases Act, 1908 (Cap 78); the Mosquitoes Act, 1911 (Cap 75); the Quarantine Act, 1915 (Cap 77); the Food and Drugs Act, 1992 (PNDCL 305B); and Sections 285–288 of the Criminal Offences Act, 1960 (Act 29).
Mental Health Act 2012 (Act 846)	<ul style="list-style-type: none"> • Provides an elaborate statement of patients’ rights in the context of mental health.
Data Protection Act 2012 (Act 843)	<ul style="list-style-type: none"> • Provides that a person shall not process personal data relating to the health of an individual unless stated exceptions apply (§21(1)(b)).
National Health Insurance Act 2003 (Act 650)	<ul style="list-style-type: none"> • Establishes the National Health Insurance Authority (NHIA) with the mandate to “secure the implementation of a national health insurance policy that ensures access to basic healthcare services to all residents” (§2(1)). • The NHIA “ensures that healthcare services rendered to beneficiaries of schemes by accredited healthcare providers are of good quality” (§2(2)). • The NHIA is required to “devise a mechanism for ensuring that the basic health care needs of indigents are adequately provided for” (§2(2)). • The NHIA has the additional responsibility toward quality assurance and in particular: “(a) the quality of healthcare services delivered are of reasonably good quality and high standard; (b) the basic healthcare services are of standards that are uniform, throughout the country;(c) the use of medical technology and equipment are consistent with the actual needs and standards of medical practice; (d) medical procedures and the administration of drugs are appropriate, necessary and comply with accepted medical practice and ethics, and (e) drugs and medication used for the provision of healthcare in the country are those included in the National Health Insurance Drug List of the Ministry of Health” (§68).
Ghana AIDS Commission Act 2002 (Act 613)	<ul style="list-style-type: none"> • Is not directly relevant to patient empowerment, but creates a broad-based commission to coordinate the national fight against HIV/AIDS.
Traditional Medicine Practice Act 2000 (Act 572)	<ul style="list-style-type: none"> • Regulates traditional medical practice for the first time and provides a monitoring scheme, which can protect patients against exploitation by unscrupulous herbalists.

Table 12.1 Cont.

<i>Short title of statute/Delegated legislation/ Guidelines</i>	<i>Relevance to the empowerment of the patient and the regulation of medical advances</i>
GHS and Teaching Hospitals Act 1996 (Act 525)	<ul style="list-style-type: none"> • Mainly sets up the institutional framework for the delivery of health care through state-owned health institutions. • Remotely touches on patient safety by providing that the monitoring of the quality of care provided in health institutions is part of the responsibilities of the Boards established by the Act (§35(2)).
The Fourth Republic Constitution of Ghana, 1992	<ul style="list-style-type: none"> • Guarantees various human rights that can be adapted to the health care context.
Medical and Dental Council Act 1972 (NRCD 72)	<ul style="list-style-type: none"> • Deals exclusively with the regulation of the medical profession. • Establishes a council that “is concerned with medical and dental practitioners and is responsible for securing, in the public interest, the highest standards in the practice of medicine and dentistry” (§4).
World Health Organization (WHO) (Protection) Act 1958 (No. 41)	<ul style="list-style-type: none"> • Makes it unlawful to misuse or abuse the name and emblem of WHO.
Vaccinations Act 1919 (Cap. 76) [recently repealed by Act 851]	<ul style="list-style-type: none"> • Provided for free and compulsory vaccination against certain diseases.
Infectious Diseases Act 1908 (Cap. 78) [recently repealed by Act 851]	<ul style="list-style-type: none"> • Dealt with how to contain the spread of infectious diseases.

mental patients: “(2) The consent of a voluntary patient shall be obtained before treatment is given. (3) A voluntary patient reserves the right to refuse treatment” (Republic of Ghana 2012b, §40). These provisions are important indicators of the modest progress being made in Ghana toward the empowerment of patients. There is no reported case concerning these provisions of §41 (consent and refusal of treatment), so their true effects are yet to be realized.

Looking at the MHA, apart from general mental health care, a higher level of consent is required where special treatments are to be administered to mental health patients. In this regard, four aspects of the MHA are worth considering. First, “a person with mental disorder shall not undergo sterilization, a major medical or surgical procedure without informed consent or the informed consent of a personal representative if that person is incapable of giving the consent” (Republic of Ghana 2012b, §71). The MHA expressly mentions electro-convulsive therapy as one procedure that cannot be administered without informed consent (Republic of Ghana 2012b, §71(5)). It is interesting to note how the Ghanaian lawmakers have reserved informed consent for these high-risk invasive procedures. Unlike England and Wales, where no statute has specifically incorporated the doctrine of informed consent, for the first time this has been expressly incorporated in Ghanaian law. The MHA did not merely incorporate informed consent and leave the courts to work out its interpretation but went a step further to unequivocally spell out its meaning. Thus, according to §97 of the MHA, informed consent means “an agreement or consent for a procedure given freely without coercion by a person with capacity when the person has been made fully aware of the nature of the procedure, its implications and available alternatives” (Republic of Ghana 2012b). A person has capacity where he or she

possesses “the functional ability to understand or form an intention with regard to an act” (Republic of Ghana 2012b, §97). A striking feature of this statutory definition of informed consent is the requirement for full disclosure to the patient or their representative. However, the benefits of this provision are limited, as informed consent is stipulated here only in relation to mental, rather than general health care. Second, a health care facility can ignore the absence of informed consent and proceed with the requisite procedure when the life of the patient with a mental disorder could be endangered as a result of a delay caused while obtaining consent (Republic of Ghana 2012b, §71(2)). Third, in all cases of serious medical procedures for a mentally ill person, where informed consent cannot be given or is delayed, the relevant health care facility is required to apply to the Mental Health Review Tribunal for consent (Republic of Ghana 2012b, §71(2) and (3)). Finally, the MHA has made the breach of the rights of a patient with a mental disorder a criminal offense, punishable with a fine and imprisonment (Republic of Ghana 2012b, §94). Thus, a doctor or any health care professional who treats such patients without obtaining appropriate consent risks criminal prosecution. It appears from these provisions that, as far as mental health care is concerned, the issue of patient empowerment is addressed in Ghanaian law. Nevertheless, it is difficult to meaningfully assess whether there are rough edges in the law that need to be reviewed, since the provisions of the MHA are yet to be tested in the courts or the tribunal. It also needs to be emphasized that merely passing legislation with elaborate provisions on patient rights will not be, by itself, an effective solution to the conundrum of the absence of health care accountability. There would have to be socio-cultural changes as well.

Another way in which the MHA potentially advances patient empowerment is the guaranteeing of “free and full access to information about mental disorders and the treatment plan of [the mental] patient” (Republic of Ghana 2012b, §62(1)). This is a remarkable improvement in Ghanaian law, especially when one considers the situation in *Vaah* where the court had to invoke generic provisions on freedom of information as grounds for holding that the claimant was entitled access to medical records. Since there is no specific legislation on access to medical records in Ghana, except the general Data Protection Act, 2012 (Act 843) (hereafter, DPA), it is my submission that a court may now draw inspiration from the MHA when interpreting freedom of information under the 1992 Constitution, in relation to medical or health records in a similar situation to *Vaah*. In a country where there has been excessive medical paternalism and patients tend to lack the confidence to ask doctors questions concerning their clinical experience, the MHA has ushered in a brave new world. The conundrum inherent in the MHA’s approach toward access to medical records is that it permits the health facility to deny access to information about the patient’s medical disorder and treatment plan “if the information is harmful to the well-being of the patient” (Republic of Ghana 2012b, §62(3)). The question that immediately comes to fore is how we determine what constitutes “harmful information”? This provision is yet to be tested in litigation, so not much can be said beyond this observation.

Similarly, the DPA, as a general rule, exempts the processing of personal data relating to the health of an individual (Republic of Ghana 2012a, §37(1)(b)). However, this presumption may be rebutted by necessity of medical purpose where the “the processing is (i) undertaken by a health professional, and (ii) pursuant to a duty of confidentiality between patient and health professional” (Republic of Ghana 2012a, §37(6)(e)). Furthermore, there is a general prohibition of the disclosure of personal data relating “to the physical, mental health or mental condition of the data subject” (Republic of Ghana 2012a, §62(a)). This prohibition is relaxed where there is another law that requires disclosure. The real effect of the DPA in relation to health data or records cannot be assessed at present, since legislation was operationalized not long ago.⁷

The PHA has also introduced new initiatives that can potentially advance the empowerment of patient. For the first time, the GHS Patient's Charter has been given statutory basis through its incorporation into §167 of the PHA. The Charter embodies the rights and responsibilities of patients. The PHA has also established a maiden framework for conducting clinical trials.⁸ The explicit endorsement of the doctrine of informed consent is noticeable in this framework (Republic of Ghana 2012c, Part 8, §158).

In addition to statutes, there are other forms of quasi-law or “soft law” in Ghana that have significance for patient empowerment and health care accountability.⁹ The prominent example of quasi-law that I will explore first is the GHS Patient's Charter and the Code of Ethics.¹⁰ The Patient's Charter and Code of Ethics were introduced in 2002 “with the main aim of promoting an open and positive relationship between and among health workers and patients” (GHS [2002] 2017a,b). The Code of Ethics particularly defines the general moral principles and rules of behavior for all service personnel in the GHS (GHS [2002] 2017a). The Patient's Charter addresses three thematic areas:

Respect for the patient as an individual with a right of choice in the decision of his/her health care plans.

The Right to protection from discrimination based on culture, ethnicity, language, religion, gender, age and type of illness or disability.

The responsibility of patient/client for personal and communal health through preventive, promotive and simple. curative strategies.

GHS [2002] 2017b

The thematic areas addressed by the Patient's Charter are in line with General Comment Number 14: “The Right to the Highest Attainable Standard of Health” of the International Covenant on Economic Social and Cultural Rights (ICESCR) (UN-OHCHR (2000, paras. 12 and 36). The Patient's Charter embodies 14 rights and nine responsibilities for patients that all health care providers and patients are enjoined to observe. Examples of rights in the Patients' Charter are the rights to be informed about “alternative treatment(s),” “to privacy during consultation;” “the right to consent or decline to participate in a proposed research study involving him or her after a full explanation has been given,” and “to full information on his/her condition and management and the possible risks involved, except in emergency situations when the patient is unable to make a decision and the need for treatment is urgent” (GHS [2002] 2017b). The Patient's Charter not only recognizes rights but also imposes responsibilities on the patient. Thus, according to the Charter, a patient is responsible for much, including:

Providing full and accurate medical history for his/her diagnosis, treatment, counseling and rehabilitation purposes.

Requesting additional information and or clarification regarding his/her health or treatment, which may not have been well understood.

Complying with prescribed treatment, reporting adverse effects and adhering, to follow up requests.

GHS [2002] 2017b

It can be discerned from the approach used in the Charter that GHS envisages the building of a partnership between health care professionals and patients in the health care process. Clearly, such an initiative is a positive step toward patient empowerment, since the rights-based approach

to health care, depending upon the manner of its implementation and general effectiveness, could diminish the disequilibrium of power in the patient–doctor relationship in Ghana.

However, until 2012, when the PHA was enacted, the legal status of the Patient’s Charter was doubtful, since it was neither created as an Act of Parliament nor delegated as legislation. It is important to note that the PHA does not create any new right as far as patients’ interests in health care are concerned; it basically invests the extant Patient’s Charter with unequivocal legal status by repeating the content of the Patient’s Charter verbatim as the Sixth Schedule to the PHA (Republic of Ghana 2012c, §167). The Charter constitutes an operational guideline for health providers that the GHS is mandated to regulate. It is important to point out that the teaching hospitals are not subject to regulation by the GHS and so may not follow the prescriptions of the Charter.¹¹ Despite not being an Act or a formal delegated legislation, the Patient’s Charter has become a *de facto* framework for patient’s rights discourse in Ghana’s health sector. See, for example, Abekah-Nkrumah, Manu, and Atinga (2010), who conducted empirical research seeking to determine the extent of public awareness of the Charter and individuals’ readiness to assert their rights as patients. Their findings show that “the majority of patients (53.4 per cent) are not aware of the existence of the Charter; of those that know about it, a sizeable minority (33.7 per cent) are not knowledgeable about its contents” (Abekah-Nkrumah, Manu, and Atinga 2010, 169). Unlike the patients, the providers of health care “exhibit better awareness (61.8 per cent) and content knowledge (61.8 per cent) of the Patient’s Charter, but on the whole are not yet carrying out their responsibilities under it” (Abekah-Nkrumah, Manu, and Atinga 2010, 169). From the empirical findings, it emerges that patients who are supposed to be beneficiaries of rights in the Charter are not sufficiently aware of its existence or its content.¹² It is even more worrying when one considers the socio-demographic matrix of the research. The paper indicates that “this is an initial exploratory research with a limited sample, which was biased towards the educated” (Patients Association 2012, 169). It is thus likely that the degree of awareness among the illiterate population would be shockingly low. According to statistics from the 2000 Census, only 57.9 percent of Ghana’s population is literate.¹³ The lack of awareness of the Patient’s Charter will impede litigation for the ventilation of these rights. Careful research involving a search through all the available law reports from Ghana indicate that there is no reported case relating to the Patient’s Charter.¹⁴ It is, therefore, fair to conclude that most Ghanaians continue to be ignorant of the Charter and the rights stipulated in it.

The empirical findings that have been presented are also corroborated by the annual report on the state of human rights in Ghana published by the CHRAJ. Fieldwork undertaken by the CHRAJ, and reflected in its 2011 annual report, confirmed this massive lack of awareness among the population. The report further revealed that there were “no clear Government or institutional plans” toward creating awareness of or enforcing of the Patient’s Charter. The only significant mode of accessing information on the Charter is through posters and fliers in health institutions (CHRAJ 2010, 111).

However, these plans are not present in every health institution, or in a language (English) that can be read nor understood by the masses (CHRAJ 2010). In most cases, health personnel who are supposed to inform patients on their admission to the hospital of their rights under the Charter do not do so. In sum, “[i]nadequate staff strength coupled with increasing workload (hospital attendance), inadequate funds to carry out education programmes, and lack of rooms to ensure clients’ privacy and confidentiality are some of the major challenges in achieving the objectives of the Charter” (CHRAJ 2010, 111). It is instructive to note that the need to actively create awareness of the existence and content of the Charter in Ghana is imperative since, even in England, with a high literacy rate and easily accessible information, a large segment of the

patient population remains ignorant of the NHS Constitution, which serves the equivalent function as the Charter in Ghana (Patients Association 2012). There is the urgent need for the issue of accountability of health care professionals, given the teeming incidence of violation of patients' rights and medical negligence that should be investigated thoroughly with requisite media prominence. In this regard, the chapter seeks to explore the opportunities and prospects that exist in the 1992 Constitution for holding well-structured public inquiries.

Assessing the utility commissions of inquiry to enhance accountability in health care delivery

The development of a robust health care law and policy that better safeguards patients' rights will be enhanced (and better rationalized) if an official account of the exploitation of patients' vulnerabilities is generated. This may be achieved by commissioning a public inquiry to undertake detailed investigations into patients' experiences and the operations of selected health institutions in Ghana. The findings and recommendations from such an inquiry could greatly assist in addressing fundamental issues affecting clinical safety and accountability, the professional culture in the health care system, and the rights of patients. This suggested initiative, if adopted in Ghana, would not be unprecedented.

Public inquiry, by whatever designation, has been deployed in other jurisdictions, including the United Kingdom, for various purposes including discovering "the 'facts' concerning individuals' and/or organizations' behavior, or to explain personal and/or organizational failings as a basis for developing higher standards of care and reforming policy" (Black and Mays (2013, 129). In England and Wales, for example, public inquiries into the health care system have played an influential role in setting aspects of the agenda for HCL and policy reforms (Kennedy 2001). There have been many public inquiries into health care delivery in England and Wales during the last four decades (Bristol Royal Infirmary Inquiry 2002). The most recent, the Francis Inquiry, for example, sought to investigate serious failings at Mid Staffordshire NHS Foundation Trust. Worthy of note is a poignant observation made by Francis (2013, 3, Executive Summary): "There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care." Thus, the inquiry advanced accountability in health care by exposing regulators and professional bodies who were either negligent or inefficient in the discharge of their duties toward patients. Although the real impact of public inquiries in the United Kingdom and other jurisdictions cannot be measured with mathematical precision. Apart from assuaging public anxieties about happenings in the health sector, the public inquiries have other utility; a more empirical work may be necessary before one could be quite certain regarding the soundness of public inquiries reporting as a basis of public policy or legislative choices (Black and Mays 2013, 131). While public inquiries in some jurisdictions are established in accordance with an Act of Parliament, such inquiries have been given constitutional status, since Ghana returned to constitutional democracy.

A constitutional democracy thrives on rule of law and due process. Ordinarily, the judicial system, through its adjudication processes, should ensure that abuse of power is checked by holding power wielders accountable. Nevertheless, the adjudication process can be useful in the task of ensuring that power wielders are answerable only where a factual scenario has crystallized, which enables meaningful deployment of adjudication resources. Regrettably, there are many instances in which abuse of power and exploitation of the vulnerable may be suspected, but the constraints of the adversarial system of litigation could militate against resort

to the conventional adjudication mechanism. As a panacea to this agonizing conundrum, the framers of the 1992 Constitution of the Republic of Ghana have, in their profound wisdom, provided for the power of the President of the Republic to constitute a Commission of Inquiry on an ad hoc basis to embark upon investigation of any subject matter that is considered to be relevant to national interest (Republic of Ghana 1992, art. 278). The constitutional system in Ghana has already made provision for the use of public inquiries as a tool to probe matters of public interest. According to art. 278 of the 1992 Constitution of Ghana:

1. Subject to Article 5 of the Constitution, the President shall, by constitutional instrument, appoint a commission of inquiry into any matter of public interest where—
 - a. the President is satisfied that a commission of inquiry should be appointed, or
 - b. the Council of State advises that it is in the public interest to do so; or
 - c. Parliament, by a resolution requests that a commission of inquiry be appointed to inquire into any matter, specified in the resolution as being a matter of public importance.

Republic of Ghana 1992, art. 278

Thus, there are three ways in which the power to set up a commission of inquiry may be deployed. The critical test for invocation of the power in all three circumstances is the need to serve the public interest. The Constitution defines “public interest” as including “any right or advantage which enures or is intended to enure to the benefit generally of the whole of the people of Ghana” (Republic of Ghana, art. 295). The broader definition of “public interest” presents an enormous opportunity for formal investigation into any matter that affects the generality of the population. Undoubtedly, the issues of patient safety and patients’ rights can easily satisfy the test of public interest, since almost every person, at a given point in time, may become a patient. It is submitted, therefore, that probing the operations of some of the selected health care institutions in Ghana and how they impact patients’ rights and safety are sufficient justification for the use of the constitutional power to set up a commission of inquiry. Notwithstanding the existence of this constitutional facility, no commission of inquiry has ever been established to investigate any matter relating to health care in Ghana. It is quite striking that since the commencement of the 1992 Constitution, at least 10 commissions of inquiries have been set up to probe political matters.¹⁵ The issues investigated by these commissions of inquiry were often debated in the media in the same way that the many incidences of medical malpractices and scandals in health care are given media spotlight. The budgets of these commissions of inquiry are funded by the government (Republic of Ghana 1992, art. 295). Since the nuances of clinical operations of health care institutions in Ghana in relation to patients’ experiences have never been subjected to an evidence-based public discourse, the setting up of a commission of inquiry into that subject may help to create a national awareness of the subject and the building of a consensus nationwide on how to address safety and patient rights in the country, within the constraints of available health care resources. It is pertinent to note that there exist constitutional limitations on the scope of matters, which can be the subject matter of inquiry by a commission of inquiry appointed under the Constitution. Opong (2002) rightly observed that the decision to appoint a commission of inquiry is primarily a political decision for the government and is not amenable to judicial review, unless it can be shown that some constitutional or statutory limitation has been breached.

A commission of inquiry is obliged to report in writing the results of its inquiry. As the commission is appointed by the president, its report is sent to the president who must cause it to be published, together with the white paper on it, within six months after the date of

the submission of the report, or, when the report is not to be published, issue a statement to that effect, giving reasons why the report is not to be published (Republic of Ghana 1992, art. 280(3)). This requirement of publication represents an attempt to satisfy the public's right to know. A commission of inquiry is the guardian of the public interest, since it is appointed to inquire into matters of "public interest." The white paper is a statement of the government's position on particular issues addressed in the commission's report. It represents the government's view on the issue. The mandatory requirement for a white paper to accompany the publication of the report of commissions of inquiry was introduced in the 1979 Constitution, but no specific reason was assigned for its introduction. It could, however, be seen as an attempt by the Executive to maintain some degree of control over the findings of the commission, while at the same time allowing the public to know the policy measures the government is taking on the report.

The contents of the white papers have been many and varied. They range from statements of appreciation and commendation for good work done to those rejecting or accepting specific findings and the policy initiatives to be taken thereon. However, the content of the white paper, as well as the actions that could be taken on it, are not large. The white paper cannot be used as a tool for arbitrary action.¹⁶

Conclusion

It has been demonstrated in the preceding section that although Ghana has legislative provisions of relevance to health care, it was not until post-2012 that it enacted statutes to directly address patient rights in a clinical and research setting. Since these statutes are relatively new and there are no cases based upon them, it is not realistic to gauge their true impact on patient empowerment. This reinforces the earlier point that having statutory provisions on patient rights are not an automatic guarantee of patient empowerment. Moreover, it has been argued that inability of victims of medical negligence and patient abuse to seek redress undermines holding health care professionals accountable. This quest for accountability in health care delivery could significantly be promoted through a public inquiry into the state of patients' experiences with the various health facilities in Ghana.

Notes

- 1 See *U.S.A. v. Karl Brandt et al.*: "The Doctors' Trial," http://nuremberg.law.harvard.edu/nmt_1_intro.
- 2 *Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother)*, Suit No. AHR 44/06, Judgment by Accra Fast Track High Court dated 24/06/2008. Unreported.
- 3 Unreported, but the suit number is HRCM 69/10 Fast Track Court, High Street, Accra, Ghana.
- 4 *Somi v. Tema General Hospital* (1994–2000) CHRAJ 196.
- 5 *The State v. Kweku Nkyi* [1962] 1 G.L.R. 179–199.
- 6 For the legal significance of "shall," see the Interpretation Act, 2009 (Act 792) §42: "In an enactment the expression 'may' shall be construed as permissive and empowering, and the expression 'shall' as imperative and mandatory."
- 7 See www.dataprotection.org.gh/about-us/the-commission.
- 8 See Part 8 of the Public Health Act 2012 (Act 851) (Republic of Ghana 2012c); see further details with respect to informed consent in Ghana in Owusu-Dapaa (2016).
- 9 The term "soft" or "quasi-law" was first introduced into the discussion of sources of HCL by Jonathan Montgomery (Owusu-Dapaa (2016, 207–10)).
- 10 Other examples of quasi-law are guidelines include the Ministry of Health, "Ghana Health Service Guidelines for Case Management of Malaria in Ghana" (Accra, 2004); Ministry of Health, "Ghana Health Service, National Guidelines for Laboratory Diagnosis of Malaria" (Accra, 2009).
- 11 Ghana Health Service and Teaching Hospitals Act 1996 (Act 525).

- 12 A similar survey with respect to the National Health Service Constitution was conducted by the Patients Association in the UK (Patients Association 2012).
- 13 See www.indexmundi.com/ghana/demographics_profile.html.
- 14 The law reports in Ghana are “Ghana Law Report,” “Supreme Court of Ghana Law Report,” “Ghana Bar Law Report,” and “Ghana Monthly Law Report.”
- 15 For example, the Constitutional Review Commission set up by the Constitution Review Commission of Inquiry Instrument 2010 (C.1 64); the Ghana @ 50 Commission of Inquiry set up by the Commission of Inquiry (Ghana @ 50) Instrument 2009 (C.I. 61); the Judgment Debt Commission.
- 16 *Quayson v. Attorney General* [1981] GLR 295.

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