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LICENSED TO KILL? CONTEXTUALISING MEDICAL MISCONDUCT, MALPRACTICE AND THE LAW IN GHANA

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ABSTRACT

Now, more than ever, the Ghanaian patient is better informed, more discerning and increasingly aware of his/her healthcare rights and options. Despite the rate of awareness, scholars have paid less attention to some medicolegal issues in the country. This paper examines the prevailing regime of healthcare delivery and regulation, and attempts to construct the context of medical misconduct and malpractice in Ghana. Using a desktop approach, the study made use of secondary data such as news articles, journal publications, and statutes, among others. The analysed data indicate that what determines professional-patient relationship outcomes are contextual issues of regulatory, institutional, political, socio-cultural, and legal. It is proposed that any prosecution or adjudication of malpractice claims, or considerations for medical law reforms, must be done with due regard to the prevailing context, if just and suitable ends are envisaged.

Keywords: Medical law, Malpractice, Misconduct, Medico-legal, Negligence, Regulation

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Introduction

Missing babies, patient abuse, wilful neglect of patient wishes, wanton refusal to attend to the sick, baby-selling—these are immediate notions that a cursory exploration of medical malpractice in Ghana may reveal.[3] However, the few reported incidents that touch on the subject raise critical issues which fuel the idea that these events may not be isolated but consistent with a certain identifiable context within which medicine is practised in Ghana. We argue that medical malpractice, and (or) misconduct in the country occur within a unique context of regulatory, institutional, political, socio-cultural, and legal arenas. Hence, any attempt to conceptualize these subjects without reference to the argued context might be fatal to the outcome.

According to Black's Law Dictionary, medical malpractice occurs when a doctor fails to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances.[4] It appears that medical malpractice could generally be regarded as tortfeasance or fall within tort law, and the term is likely to be confused with medical negligence.[5] However, even as a tortfeasance, medical malpractice may assume the form of assault, battery, defamation, false imprisonment or otherwise, which differ from negligence. Consequently, medical malpractice and medical negligence are not strictly coterminous.

Medical malpractice ordinarily arises from a contractual relationship with the patient[6] and depending on the nature of the wrongful conduct, there may be criminal implications.[7] AL Perry thus argued that 'the term is so broad that any professional misconduct arising through ignorance, carelessness, want of proper skill, disregard of established rules, criminal intent, is included in the definition.'[8] In American jurisprudence, medical malpractice has gained popularity from the prosecution of related

[3]An in-depth illustration of these observations is given in the ensuing discussions.

[4] BA Garner (ed), Black's Law Dictionary (10th edn Thomson Reuters, St. Paul 2014).

[5] AL Perry, 'Malpractice in Dental Anaesthesiology' (1964) 13 Clev.-Marshall L. Rev. 319.

[6] MS Pandit and S Pandit, 'Medical negligence: Coverage of the Profession, Duties, Ethics, Case law, and Enlightened Defense - A Legal Perspective' (2009) 25 Indian J Urology 372, 378; See *Thake v. Maurice* [1986] 2 WLR 337 and *Eyre v. Measday* [1986] 1 All ER 488, where the plaintiffs sued their doctors for a breach of contract, claiming damages for failed sterilization procedures that resulted in unplanned pregnancies.

[7] According to Section 51 of the Criminal Offences Act, 1960 (Act 29) a negligent conduct that amounts to a reckless disregard for human life and causes death can be the subject of a manslaughter charge.

[8] Ibid (n 3).

claims over time.[9] In one notable judgement, the US Supreme Court has defined medical malpractice as 'the unwarranted departure from generally accepted standards of medical practice resulting in injury to a patient, *including all liability-producing conduct arising from the rendition of professional medical services*.'[10] The court noted that it is when a medical malpractice claim sounds in negligence that the elements of negligence apply. Therefore, a proper construction of medical malpractice cannot be limited to medical negligence. What constitutes medical malpractice must then be understood as capable of resulting in either criminal, contractual, or tortious liabilities, of which negligence is only a constituent. It is also possible that a particular malpractice may amount to a constitutional breach, which may form the basis of a constitutional action.[11]

The case of *Elizabeth Vaah v. Lister Hospital and Fertility Centre,*[12] although not premised on malpractice, may be cited for purposes of reference. In that case, a client who was under the care of the defendant hospital sued the hospital successfully, relying on the right to information guaranteed under Article 21(1)(f) of the 1992 Constitution of Ghana (the Constitution), when she sought to recover her medical record to clarify the cause of death of her stillborn baby. Also, in *Somi v. Tema General Hospital*,[13] the Commission on Human Rights and Administrative Justice (CHRAJ) found the defendant hospital to have unjustly caused a patient's death in violation of Article 218(a) of the Constitution. An understanding of the foregoing distinctions is necessary to avoid the potential legal confusion surrounding the broad usage of the term medical malpractice. In the Ghanaian clinical setting, the medical professional may rather be more familiar with the term *medicolegal issues* than with medical malpractice, owing to popular usage. The Ghana Health Service, for instance, has a Medico-Legal Unit. This familiarity or awareness appears to be associated with increasing malpractice claims in the country. Medicolegal issues generally refer to matters of clinical practice that invoke questions of law, as medical malpractice issues are medicolegal issues. In this paper, these two

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[9] S Bal, 'An Introduction to Medical Malpractice in the United States (2009) 467 Clin Orthop Relat Res 339, 347.

[10] *Toogood v. Owen J. Rogal, D.D.S., P.C.,* 573 Pa. 245, 824 A.2d 1140, 1145 (2003) (emphasis added).

[11] Articles 28 (4) and 30 of the 1992 Constitution of Ghana, for example, provide constitutional controls for clinical decision-making pertaining to children and other persons on the basis of incapacity, religious beliefs, etc. Articles 13 and 15 also guarantee the right to life and human dignity respectively. An aggrieved patient can pursue a claim on these.

[12] Suit Number HRCM 69/10. Unreported judgment of the Fast Track High Court, High Street, Accra, Ghana; See discussion in I D Norman and others, 'The Constitutional Mandate for Judge-Made-Law and Judicial Activism: A Case Study of the Matter of Elizabeth Vaah v. Lister Hospital and Fertility Centre' (2012) 6 The Open Ethics J 1,7.

[13] (1994-2000) CHRAJ 196; [2000] DLCHRAJ5729.

terms (i.e., medical malpractice and medicolegal issues) will be used liberally and interchangeably.

A misconduct is a neglect or dereliction of duty; or an unlawful, dishonest or improper behaviour, usually by a person in a position of authority or trust.[14] This rendition of the term has moral, criminal, contractual and tortious inferences. Pertaining to dereliction of duty, for instance, wilful omission to act to prevent a felony by a patient[15] or procuring the death of a patient (assisted death or euthanasia)[16] may lead to prosecution of the Ghanaian medical professional. On the contrary, a breach of duty owed to the patient may suffice as basis for a case in medical negligence, despite that such an event would ordinarily flow from a contract of care. These observations lead to the conclusion that an act which is the subject of medical misconduct may, in law, have implications identical to those of medical malpractice. However, the scope and applicability of either term in Ghanaian law vary and the nuances are subsequently illustrated. This paper aims at contextualizing malpractice, and misconduct within the contexts stated above, as well as its applicable laws in Ghana. Unless otherwise suggested within the context, arguments advanced in this paper are not restricted to medical doctors. Rather, extension is made to nurses, psychologists, pharmacists, allied health personnel, and other medical professionals who partake in the patient caregiving process.

Methods

To make our argument cogent, we reviewed relevant statutes and cases identified in the Ghana Law Finder, Dennislaw, and Ghalii databases, in addition to legal textbooks. Search terms included medical negligence, medical misconduct, medical malpractice, regulation, nurse, doctor, health, patient, negligence, allied health, and pharmacy. All statutes considered were to the best of our knowledge effective as of October 31, 2021. Journal articles from online sources were retrieved from their relevant databases using Google Scholar as the starting point. Media reports were identified using the Google search engine. Analyses were drawn from the relevant documents, focussing on medical misconduct, malpractice and applicable laws in Ghana; and the observations were conceptualised to construct a Ghanaian context.

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[14] Ibid (n 2).

[15] Section 22 of the Criminal Offences Act, 1960 (Act 29) places a duty on persons in Ghana to act to prevent others from committing felonies.

[16] According to section 42(a) of the Criminal Offences Act, 1960 (Act 29), the killing of a person cannot be justified on the ground of consent. Therefore, beyond ethical lines, a medical professional who unlawfully agrees with a patient to help that patient kill himself may open himself up for criminal inquiry.

Statutory Definition and Scope of Medical Misconduct in Ghana

The term medical malpractice seems alien to Ghanaian statutes, as current legislations in the country do not expressly use or define this term. The Health Professions Regulatory Bodies Act, 2013 (Act 857) lays out a regulatory regime for allied health professionals, doctors, nurses, pharmacists and psychologists in the country. In this Act, specific reference is rather made to *professional misconduct* but the Act does not define this term. This notwithstanding, the Act empowers governing Boards of the various regulatory councils established under the Act to investigate and sanction for professional misconduct. For instance, the Nursing and Midwifery Council (NMC) may be authorised by its governing Board to remove from its register the name of a person who has been found 'guilty of professional misconduct by a disciplinary committee' established by the Board.[17] Criminal offences and civil wrongs are tried and punished by courts and tribunals established under the Constitution. But if a conduct, which is the subject of a criminal or civil action, is also perceived as professionally unacceptable by a regulatory body, that body may treat it as a professional misconduct or infamous conduct in a professional respect and impose relevant sanctions in accordance with the applicable laws.

In the case of *Dr. Sandys Arthur v. The Ghana Medical Council*,[18] the Court of Appeal clarified a phraseological confusion arising from the Medical and Dental Act, 1972 (NRCD 91) and ruled that professional misconduct or infamous conduct in a professional respect is not a criminal offence per se. The court observed that although finding a professional 'guilty of misconduct' by a regulatory body has the connotation of criminal inquiry, that phraseology could not be interpreted as conferring a criminal jurisdiction; neither could professional misconduct come within the contemplation of Article 19(11) of the Constitution, which requires that criminal offences be defined and penalties provided by statute. According to the court, professional misconduct only 'connotes an infraction of professional conduct and ethics.' Also, the court noted that despite the procedure for the determination of infamous conduct or that professional misconduct may mimic criminal procedure, it does not make it a criminal trial. The effect of this ruling is that infamous conduct in a professional respect or professional misconduct for that matter is not legally recognised as a crime but a professional wrong, even though the underlying conduct may be criminally punished by a proper court of law. Act 857, which

[17] Act 857, s 67(1).

[18] Civil Appeal No. H1/214/2012. Unreported judgement of the Court of Appeal dated 31st July 2012.

was passed after the decision in *Dr. Sandys Arthur*'s case in 2012, has nonetheless retained similar phraseology, along with its confusion.

In the Nurses and Midwives Act, 1972 (NRCD 117),[19] *professional misconduct* is also used in the disciplinary provisions and is not defined. Under the said disciplinary provisions, a nurse or midwife may be reprimanded, suspended, removed from the register of practitioners, or ordered by the Board to pay costs, where it is proved that he or she has been convicted of an offence; has been found to be of questionable professional character by a judicial authority; or has been guilty of a conduct, which sufficiently constitutes professional misconduct.[20] It may be inferred from NRCD 117 that what constitutes professional misconduct under the statute is not merely confined to professional relations with the patient but extends to acts of criminality and moral turpitude which may have negative implications for professional reputation. This expansive character-fitness or fitness-to-practice control extends to student nurses.[21] Under the current regulatory regime, the NMC determines what behaviour amounts to professional misconduct on the basis of which it may sanction a nurse or midwife. In order to curtail the excesses of this power, the Act grants a nurse or midwife, who has reason to challenge a decision of the Board, a right of appeal to the High Court.[22] But independent of the Act, the High Court has an inherent power to supervise all administrative or lower adjudicatory bodies, and the NMC falls within this category of bodies when it exercises its disciplinary or regulatory powers.[23] Additionally, the

[19] This Act provided a regulatory regime for nursing and midwifery practice in Ghana until it was repealed by the Health Professions Regulatory Bodies Act, 2013 (Act 857). Despite the repeal, the disciplinary provisions (Sections 26-32) together with subsidiary regulations made under it were saved by section 77 of Act 857 to continue in force.

[20] Nurses and Midwives Decree, 1972 (NRCD 117), ss 27 and 29.

[21] Regulation 21 of the Nurses Regulations, 1971 (LI 683) empowers the NMC Board to order the removal of a pupil nurse from the student index if it is satisfied that his conduct is such that he will not be fit to practice as a Registered Nurse.

[22] Nurses and Midwives Decree, 1972 (NRCD 117), s 30.

[23] Article 141 of the 1992 Constitution confers on the High Court the jurisdiction to supervise any lower adjudicatory authority and to issue such orders and directions as are necessary for exercising this jurisdiction. According to Article 161, this supervisory jurisdiction includes the power to quash or set aside decisions of a lower adjudicatory body (certiorari), prevent that body from further acting unlawfully (prohibition), compel it to perform its lawful duty (mandamus), or question the authority by which that body acted (quo warranto). In *Republic v. The Registrar, Medical and Dental Board; Ex Parte Christian* [1973] 2 GLR 323-342, a medical doctor secured an order from the High Court to quash the decision of the Ghana Medical and Dental Board for removing his name from the register of practitioners, on account of professional misconduct. He claimed that he was not personally served a copy of the Board's decision

disciplinary jurisdiction of a regulatory authority such as the NMC and that of the court are not mutually exclusive with respect to pursuing a complaint about the conduct of a nurse or midwife by an aggrieved patient or complainant.[24]The reason is that the two establishments have different mandates and powers under the law. Therefore, the 'remedies' either institution may give to a complainant may differ. Under NRCD 117, the NMC has only a four-fold disciplinary power which does not extend to criminal prosecution or remedies in tort or contract.[25] Therefore, if an aggrieved patient was seeking damages for a nurse's negligent conduct, the appropriate institution would be the court. Similarly, criminal conduct may only be tried by the court at the instance of the Attorney-General.[26] But if the aggrieved patient thought that the nurse was not professionally fit to treat any other patient, or that the nurse needed to be disciplined professionally, then he/she may complain to the NMC for that nurse to be investigated and sanctioned appropriately; and this sanction would be independent of any other liabilities that a court may hold against the nurse in respect of the impugned conduct.[27]

In accordance with the Medical and Dental Act, 1972 (NRCD 91),[28] a medical practitioner may be investigated and sanctioned by the governing Board of the Medical and Dental Council (MDC) for committing a statutory offence or if found 'guilty' of

in accordance with the Medical and Dental Act, 1959. The order was, however, reversed by the Court of Appeal, which found that the doctor's solicitor was served a copy of the decision.

[24] See *Commission on Human Rights and Administrative Justice v. Norvor* [2001-2002] 1 GLR 78 where the High Court held that where different enactments provide alternative avenues for redress of a grievance, a complainant has the liberty to proceed under any of them, except that it may not be appropriate to pursue all options simultaneously, for procedural reasons.

[25] Nurses and Midwives Decree, 1972 (NRCD 117), s 29.

[26] Article 88(3) of the 1992 Constitution of Ghana places the prosecutory powers of the state under the authority of the Attorney-General. Hence, even if in the opinion of a regulatory authority a particular conduct was criminal, it would have to notify the Attorney-General for the necessary action to be sanctioned. See *Dr. Sandys Arthur v. The Ghana Medical Council* (footnote 16).

[27] Ibid (n 18). Since the powers of the NMC are defined, there is a fetter on what orders it may make. But a court may independently determine a claim in tort (negligence, assault, battery, etc); contract; or any criminal matter underlying a professional misconduct.

[28] Section 52 of the Health Professions Regulatory Bodies Act, 2013 (Act 857) repealed the Medical and Dental Act, 1972 (NRCD 91) which until the enactment of Act 857 regulated medical practice in Ghana. Despite the repeal, Part VII (ss 42-47) of NRCD 91 which relates to disciplinary matters concerning medical practitioners was saved. Part VII is to continue in force as if enacted under Act 857 until amended or repealed by subsequent legislation.

infamous conduct in a professional respect.[29] The Board may sanction by reprimanding or suspending that practitioner; removing his name from the register of practitioners; or ordering him to pay costs on the recommendation of a disciplinary committee.[30] Although the existing disciplinary provisions under NRCD 91 uses the term *infamous conduct in a professional respect* rather than *professional misconduct* which is used in Act 857, the effect of section 52 of Act 857 is that the two terms should have the same meaning. The only difficulty is that *infamous conduct in a professional respect* has also not been defined statutorily; neither is the scope of the term outlined. Under the Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023),[31] the Disciplinary Committee of the MDC Board is clothed with authority to determine what action or conduct constitutes infamous conduct in a professional respect in each disciplinary case before it.[32] Here, too, there is a right of appeal to the court where a medical practitioner has cause to question a determination of the Board.[33] In the absence of a statutory definition for infamous conduct, however, the common law definition may apply.[34] To begin with, the common law recognises that the essential

[29] Medical and Dental Act, 1972 (NRCD 91), s 42. The court in *Dr. Sandys Arthur v. The Ghana Medical Council* (See footnote 16) has now clarified the confusion as to criminal connotation of the use of the word 'guilty' with 'infamous conduct in a professional respect.'

[30] Section 43(2) of the Medical and Dental Act, 1972 (NRCD 91) provides that the disciplinary committee, if satisfied on the facts that a disciplinary case has been made out against a practitioner, may (a) reprimand the practitioner, or (b) suspend the practitioner from practice for a period determined by the committee, or (c) direct the registrar to remove the name of the practitioner from the register, or (d) suspend or postpone the giving of the direction to the registrar for the period specified by the committee; and make an order as to costs.

[31] The Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023) is a subsidiary legislation made under the Medical and Dental Act, 1972 (NRCD 91). Despite that NRCD 91 is repealed, LI 1023 was continued in force by the Health Professions Regulatory Bodies Act, 2013 (Act 857).

[32] Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023), reg 14.

[33] Medical and Dental Act, 1972 (NRCD 91), s 46. Under the stated section, reference of appeal is to the Court of Appeal, as opposed to the High Court for questions arising from decisions of the NMC Board made under the Nurses and Midwives Decree, 1972 (NRCD 117).

[34] Article 11 of the 1992 Constitution of Ghana names the common law as a source of law in Ghana. According to the Constitution, the common law comprises the rules generally known as the common law, the doctrines of equity and the rules of customary law including those determined by the Superior Courts of Judicature (The High Court, Regional Tribunals, Court of Appeal, and the Supreme Court). By this, the Constitution allows judges to make laws through their decisions on matters coming before them. Common law rules include principles from relevant court cases determined in common law jurisdictions, including Ghana. These judicial decisions serve as precedents and authority for determining future matters bordering on similar issues. Judge-made laws become particularly relevant where there are no applicable legislations to guide judicial decisions.

purpose of disciplinary or fitness-to-practice proceedings by a regulatory board is not necessarily to punish the medical professional but to protect the general public from potential harm by a practitioner whose conduct invites such inquiry. In *Ziderman v. General Dental Council,*[35] the Privy Council thus noted:

> The purpose of disciplinary proceedings against a dentist who has been convicted of a criminal offence by a court of law is not to punish him a second time for the same offence but to protect the public who may come to him as patients and maintain the high standards and good reputation of an honourable profession.

This view aligns with our earlier observation that the disciplinary authority of a Board under the relevant regulatory enactments is independent of prior prosecution or legal liabilities of the medical professional in respect of the same misconduct. Mention must be made, however, that by section 43(2) of the NRCD 91, the Board has a fettered authority that does not extend to granting damages or other reliefs in favour of aggrieved or injured complainants.[36] Such complainants would then be expected to fall on the regular court to prosecute their claims.

Infamous Conduct Defined Under the Common Law

The most adopted common law definition of infamous conduct in a professional respect was stated in the case of *Allinson v. General Council of Medical Education and Registration*[37] as follows:

> If it is shewn that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council to say that he has been guilty of infamous conduct in a professional respect.

The court observed, however, that it did not seek to proffer an exhaustive explanation to the term. In the instant case, a medical practitioner was alleged to have published some malicious advertisements about his peers in order to create public distrust in them

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[35] [1976] 2 All ER 334.

[36] The Supreme Court of Ghana, in the case of *Commission on Human Rights and Administrative Justice v. Attorney- General* [1999 - 2000] GLR 697- 720, has ruled that quasi-judicial and lower adjudicatory bodies could not exercise jurisdictions not conferred on them by statute. Thus, unless the relevant provisions are amended to extend the Boards' powers, a departure from the statutorily conferred powers would have no justification in law.

[37] [1894] 1 Q. B. 750.

and to cause the public to rather seek treatment from him. The court decided that if the allegations were proved, then the doctor should be guilty of infamous conduct in a professional respect.[38] This definition has subsequently been adopted in other common law jurisdictions. In the case of *Hoile v. The Medical Board of South Australia,*[39] a married doctor was found to have had sexual relations with a nurse in the hospital where they both worked. Some of the affairs took place in patient cubicles and on occasions when the nurse was the only nursing staff on duty. The Medical Board found him guilty of infamous conduct in a professional respect, and this was affirmed by the court on appeal. In justifying their decision, the Board maintained that the doctor abused 'the relationship which arose directly out of his status as a Medical Practitioner and the Superintendent of the Hospital,' and concluded that it had no doubt that his conduct 'would be condemned by right-thinking medical men.'[40]

The instant case may be compared to *Yeong v. The Medical Council*[41] where a married medical practitioner was suspended for having improper sexual relations with his female patient. Also, in *Meadow v. General Medical Council*[42], an English court took the position that a medical practitioner who knowingly gave false evidence as an expert witness during a civil or criminal action could be the subject of a fitness-to-practice investigation by a regulatory board. In the case of *Dekker v. Medical Board of Australia*[43], however, a court of appeal set aside a decision of the Western Australian Medical Board to discipline a doctor for failing to stop her car to help passengers of another vehicle with which her car had nearly collided. The Board was of the opinion that there was a sufficiently close connection between her conduct and her profession whose core mandate was saving lives. Therefore, failure to stop, assess and assist when she was aware that an accident might have occurred fell within the scope of infamous conduct in a professional respect. Among the reasons given by the court for setting aside the Board's decision were that

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[38] Section 29 of the repealed English Medical Act of 1858 empowered the General Council to erase from the register of medical practitioners the names of persons found guilty of infamous conduct in a professional respect. Note: In Ghana, Regulation 3 of the Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023) also prohibits advertisements by medical doctors that are intended to attract business unfairly.

[39] (1960) 104 CLR 157.

[40] Ibid. Note: Regulation 5 of the Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023) provides: 'It is an offence against professional ethics for a practitioner to abuse his special access to a patient by way of adultery or any other improper association with the patient at the material time.' This appears to be a codification of the common law position.

[41] [2010] 1 WLR 548.

[42] [2007] QB 462.

[43] [2014] WASCA 216.

the evidence on record was not sufficient to support the decision; that there were no clear guidelines specifying the doctor's duties in such situations at the time; and that there was no evidence that such a duty was generally accepted by members of the profession.[44]

It can be deduced from the above that infamous conduct in a professional respect transcends acts of professional negligence to situations of moral or ethical failure on the part of the medical professional and serves a dual purpose of preserving the integrity of the medical profession and protecting public interest of which the patient is a potential beneficiary. This arguably encompasses conducts of the medical professional which are capable of resulting in criminal, tortious or contractual liabilities. As pointed by the court in the *Hoile*[45] case, not all serious departures from the standards of moral conduct amount to infamous conduct in a professional respect, but if an act is traceable to a professional relationship and is sufficiently serious, it may properly fall within the scope. Again, it may be observed that although certain misconducts of a medical professional may not occur in the course of his professional duties or would not ordinarily be held to be a misconduct in any other person, they may constitute infamous conduct in a professional respect when associated with a medical professional. Lord Esher in the *Allinson* case put it this way:

> There may be some acts which, although they would not be infamous in any other person, yet if they are done by a medical man in relation to his profession, that is, with regard either to his patients or to his professional brethren, may be fairly considered "infamous conduct in a professional respect"[46]

Regarding the degree of seriousness of misconduct necessary for regulatory intervention, the court in the *Meadow* case adopted the view that the alleged misconduct must be linked to the practice of medicine or otherwise brings the profession into disrepute. The court further noted:

> Whether it can properly be regarded as "serious" professional misconduct, however, must depend on the circumstances, including with

[44] See discussion in HN Goiran and E Storer, 'A Tale of Two Doctors: A Comparison of The Dekker and Nitschke' <https://static1.squarespace.com/static/5c7f6297b10f25f3e868e2d2/t/5c80d0059140b7124b93c3a1/1551945735326/2002-2014-Dekker-and-Nitschke1.pdf> accessed 3 September 2021.

[45] Ibid (n 37).

[46] Ibid (n 35).

> what intention and/or knowledge and understanding he strayed from his expertise, how he came to so, to what possible, foreseeable effect, and what, if any, indication or warning he gave to those at the time.[47]

In *Dr. Sandys Arthur v. The Ghana Medical Council*,[48] the Disciplinary Committee of the MDC found a doctor 'guilty' of infamous conduct in a professional respect when he failed to properly diagnose and treat a patient, which resulted in the death of the patient. The basis of the MDC's decision was that the doctor was negligent, as he diagnosed the patient with torn ligament when Deep Vein Thrombosis (DVT) was rather indicated under the circumstances. The MDC relied on the definition of infamous conduct in the *Allison*[49] case and sought to delete the doctor's name from the register of practitioners. When the doctor challenged this decision at the Court of Appeal, the court agreed with the MDC that the appellant's conduct amounted to an infamous conduct in a professional respect. However, the sanction of de-registration was held to be rather harsh and was substituted for a three-year suspension by the court. The court noted that Rule 32 (1) of the Court of Appeal Rules, 1997 (C.I.19)[50] gave it an unfettered power, authority and jurisdiction to determine matters that come to it by way of an appeal, and that included substituting or setting aside a sanction of the MDC.

An important conclusion from the above analyses is that professional misconduct and infamous conduct in a professional respect are coterminous in Ghanaian medical law. It is also evident that professional misconduct has a wider scope and admits a wider range of questionable medical conducts as opposed to medical malpractice. Further, regulatory authority in Ghana does not extend to granting remedies to complainants by way of damages and other restitutive reliefs, since the regulatory bodies are by their nature not set up to determine the rights and obligations of parties in the manner applicable to civil or criminal courts. Additionally, regulatory action may be independent of prior prosecution or litigation of a case against a medical professional in a regular court. Thus, although a separate case could not be made against a practitioner in court, or a civil or criminal action against that professional might have failed on some grounds, a Regulator may yet find sufficient basis for a disciplinary sanction, to the extent that the conduct

[47] Ibid (n 40).
[48] Ibid (n 16).
[49] Ibid (n 35).
[50] The said Rule reads: 'The Court may, in respect of an appeal before it, give a judgment and make an order that ought to have been made and to make a further or any other order as the case may require and an order as to cost.' Note that Article 137(3) of the 1992 Constitution of Ghana also vests the Court of Appeal with all powers, authority and jurisdiction vested in any 'court' from which an appeal is brought.

in question is believed to be unacceptable by the professional body to which that person belongs, notwithstanding any right of appeal. Conversely, it is possible that a conduct may warrant liabilities in civil or criminal court even though a Board may find no reason to question it as a professional misconduct or infamous conduct in a professional respect. A professional misconduct (or infamous conduct in a professional respect) is not considered a crime but merely a professional wrong under the current regulatory regime, since it fails the Definition Test provided under Article 19(11) of the Constitution. It is argued that even if the term is defined as a crime, the penalty prescribed and the various regulatory bodies are given jurisdiction to determine charges coming under it, the trial of any medical professional on any such charge would still require the authorisation of the Attorney-General in accordance with Article 88 (3) of the 1992 Constitution. Finally, the observations lend credence to the idea that medical professionals hold themselves to a higher standard of moral or other conduct, as should properly be expected of any advanced, lawful profession. It is this separate standard that has been recognized by the courts and which is scrutinized when a conduct becomes the subject of medical negligence.[51]

Manifestation of Medical Misconduct in Ghana

Despite a paucity of empirical data and records on litigated cases, some notable incidents observed over the past few decades that fit the description of medical misconduct may be called in aid of generally outlining the nature of medical malpractices in Ghana. An overview of these events is therefore imperative. We shall begin with an illustration of the case of *Presbyterian Hospital, Agogo v. Boateng*[52] which dealt with the conduct of a senior midwife. The midwife was on night duty when a pregnant woman, who believed she was in labour, reported. When the woman had the urge and sought to use the toilet, she felt her baby was descending. Her observation was rather dispelled by the midwife who suggested that she was not due for delivery. As she struggled back to her bed, the baby dropped on the floor. This infuriated the midwife. She insulted the woman and slapped her twice. She cut the umbilical cord and left the baby in the pool of blood until the nurse took charge of the baby. The midwife then ordered the woman to wipe off the blood herself and remove the placenta from the floor. For her conduct, the hospital dismissed the midwife. When she sought to challenge her dismissal, the Court of Appeal dismissed her action, holding that her behaviour amounted to gross negligence. Next is the story of Dr. Ram Beckley, which seized newspaper headlines in the period spanning 1994 to 2002. Dr. Beckley, a medical practitioner, was alleged to

[51] See *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582 as subsequently discussed.
[52] [1984-86] 2 GLR 381-385.

have killed humans for occultic rituals. It was also alleged that some of his victims were his patients. When he was arrested, human skulls and school uniforms were reportedly found at his residence. His prosecution failed for lack of sufficient evidence. In 2002, he was again alleged to have kidnapped and assaulted a young girl by tying her to a tree in his house. His subsequent prosecution also failed for similar reasons.[53]

The case of *Frank Darko v. Korle-Bu Teaching Hospital*[54] is also relevant for the fact that it illustrates the power relations between the Ghanaian patient and the medical professional. In that case, a surgical team at Ghana's leading public teaching hospital operated on the left knee of a minor, instead of the right knee. A crucial aspect of this case is the fact that the medical professionals of the hospital refused the boy's further care in protest of a medical negligence suit filed against the facility.[55] Further significant is the case of Dr. Sulley Ali-Gabass, a senior medical doctor at the Effia Nkwanta Regional Hospital, who was handed a 25-year prison sentence in 2015 for defiling a boy under 16 years of age.[56] He admitted having anal sex with the boy on multiple occasions. The boy, who claimed he was coerced into the affair, contracted HIV and underwent surgery to repair his anus, but the doctor denied transmitting the infection. He however disclosed his sexual tendencies, and was captured in a report as admitting: 'I don't know what to do. With this sexual thing some of us are trying our best. It's like being born with it. That urge is there.'[57] Another incident worth exploring is the stillborn-babies

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[53] Ghanaweb.com, 'Ritual Killings for Human Parts, Others - These Cases Have Shaken Ghana Since The 1980s' <https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Ritual-killings-for-human-parts-others-These-cases-have-shaken-Ghana-since-the-1980s-1343947> accessed 6 September 2021; NO Achiaw and M Mensah, 'Beckley's Alleged Victim Speaks 'I am Around' And is Willing to Appear in Court' *Daily Graphic* (Accra 8 May 2002) 1; AM Noretti, 'Tribunal Adjourns Beckley's Case' *Daily Graphic* (Accra 9 July, 2002) 40

[54] *Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother).* Suit No. AHR 44/06, 9. Unreported judgment of the Fast Track High Court, Accra dated 24/06/2008. Note: Attempt was made to obtain a copy of the judgment from the General Jurisdictions registry of the High Court, Accra sometime in October 2020 but the registry could not retrieve it. My discussion of the judgment therefore relies on the relevant references made to E Owusu-Dapaa.

[55] See discussion in E Owusu-Dapaa, 'Empowering Patients in Ghana: Is There a Case for a Human Rights-Based Health Care Law? (2015) 1 Lancaster University Ghana Law Journal 91, 114.

[56] SJ Bokpe, 'Ali-Gabass Begins 25-year Jail Term (Photos)' <https://www.graphic.com.gh/news/general-news/ali-gabass-behins-25-year-jail-term-photos.html> accessed 7 September 2021. Yin talks about imprisonment in Ghana.

[57] Myjoyonline.com, 'Gay Doctor Confesses Sodomising 16-Year-Old SHS Student' <https://www.myjoyonline.com/gay-doctor-confesses-sodomising-16-year-old-shs-student/> accessed 7 September 2021; P Semevor, 'Engaging Dr Ali Gabass Will Be an Attack on UCC's Reputation – Bono Regional Director of Children Department' <https://www.myjoyonline.com/engaging-dr-ali-gabass-will-

scandal that struck the Komfo Anokye Teaching Hospital, Ghana's second leading referral hospital, in the year 2014. A woman, who was told that her baby was stillborn, disclosed her ordeal when the facility failed to give her the said baby on demand. This incident culminated in the charging of at least seven persons who were alleged to be part of a syndicate that stole babies for sale. The charges included stealing and conspiracy to steal babies. Compelled by general public interest in the matter, the Ministry of Health gave the hospital a 14-working-day ultimatum to produce some five babies who had gone 'missing,' all of whose mothers had reportedly been told were stillborn. The Ministry ordered the doctor and the midwife who were on duty when the complainant's baby got missing to proceed on leave, and some other persons who were allegedly involved were interdicted to facilitate police investigations.[58]

Barely a few years after the stillborn-babies scandal of 2014 broke, a similar syndicate was uncovered in 2020. In this incident, which broke in 2021, the MDC and the Economic and Organised Crime Office (EOCO) caused the arrest of some medical professionals, including several others, who were allegedly part of a baby-harvesting and human-trafficking syndicate. They included two medical doctors, two social workers, four nurses, two mothers and one traditional birth attendant, some of who worked at leading hospitals in the Greater Accra Region. The syndicate reportedly sold a baby for up to ₵30,000 ($5,000) to some undercover investigators who had posed as interested buyers.[59] Finally, notice is taken of the HIV-Blood-Contamination case involving two medical practitioners of the Korle-Bu Teaching Hospital, Accra, where a doctor reported his colleague for lacing his drinking water with HIV contaminated blood. The suspecting doctor had found blood stains in his water bottle and curiously got the water clinically tested. When the test came positive for HIV, he directed his suspicion

be-an-attack-on-uccs-reputation-bono-regional-director-of-children-department/> accessed 7 September, 2021.

[58] R Quaicoe-Duho, 'MoH Gives Ultimatum to KATH to Produce Five Stillborn Babies' <https://www.graphic.com.gh/news/general-news/moh-gives-ultimatum-to-kath-to-produce-five-stillborn-babies.html> accessed 7 September 2021; BBC News, 'Ghana Hospital Given 14 Days to Find 'Missing Babies' <https://www.bbc.com/news/world-africa-26382532> accessed 7 September 2021.

[59] Myjoyonline.com, '11 Persons Arrested for Engaging in Baby Harvesting, Human Trafficking – EOCO and MDC Reveals' < https://www.myjoyonline.com/11-persons-arrested-for-engaging-in-baby-harvesting-human-trafficking-eoco-and-mdc-reveals/> accessed 7 September 2021; BBC News, 'Ghana 'Baby-Harvesting Syndicate' Arrested' <https://www.bbc.com/news/world-africa-55751290> accessed 7 September 2021.

at a colleague with whom he worked at the Department of Obstetrics and Gynaecology. The matter was reported to the police for further investigation.[60]

Drawing the Nexus to a Ghanaian Context

In law, the case of *Boateng*[61] may have both civil and criminal implications. By way of civil action, an aggrieved new mother in that situation could have sued in tort for assault and battery, or negligence. Indeed, the Court of Appeal, in that case, noted that the act amounted to gross negligence. Criminally, a prosecutor could make a case for assault and causing harm negligently, contrary to sections 84 and 73 of the Criminal Offences Act, 1960 (Act 29) respectively. Aside from legal culpability, the case evinces medical paternalism at its pinnacle and constitutes a departure of the highest order from known care standards. In current practice, it is not uncommon to see Ghanaian nurses, midwives and other medical professionals verbally abuse patients, although physical abuse is fairly an occasional occurrence.[62] The phenomenon whereby some professionals assume unfettered control over the patient care relationship and in which the patient defers his contractual and fundamental human rights to the practitioner is a reality that begs serious political, legal and other stakeholder debate. Owusu-Dapaa had observed that the situation is such that 'health professionals are free to behave towards patients as if the law and even their professional ethics imposed no obligations on them towards patients.'[63]

As subsequently discussed, this situation has regulatory, institutional, political, socio-cultural, and legal underpinnings, however subtle they may be. The *Frank Darko*[64] case further accentuates the issue of medical paternalism in Ghana. Perhaps, it would embrace some logic if the medical facility in that case was private; but refusing a citizen care for seeking lawful remedy against a wrong suffered in the care of a state hospital is a classic exemplification of excessive medical paternalism. Whichever way one looks at it, there is no sufficient justification in law for such an arbitrary conduct. Besides paternalism, the two cases raise a question of standardisation of care. Currently, Act

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[60] EE Abbey, 'Korle Bu Doctor Poisons Colleague's Water with HIV Blood' <https://www.graphic.com.gh/news/general-news/korle-bu-doctor-poisons-colleague-s-water-with-hiv-blood.html> accessed 8 September, 2021.

[61] Ibid (n 50).

[62] See further discussion in JM Dapaah, 'Attitudes and Behaviours of Health Workers and the Use of HIV/AIDS Health Care Services' (2016) Nurs Res Pract <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5225383/pdf/NRP2016-5172497.pdf> accessed 8 September 2021.

[63] Ibid (n 53).

[64] Ibid (n 52).

857 vests the development and enforcement of standards in the various regulatory councils under the authority of the Minister of Health. While commendable milestones have been achieved by these Councils over the past few decades, there may be significant challenges associated with the implementation of Act 857. For instance, it is provided in the Act that a practitioner, particularly an allied health professional or nurse, who fails to conform to practice standards of the relevant regulatory body commits an offence and is liable on summary conviction to a fine or to a term of imprisonment of not more than two years or both.[65] A countervailing observation is that there are no sufficiently codified set of standards by the regulatory bodies against which questionable conducts may be proved.

It is important to note that there are distinctions between institutional practice and policies, and regulatory standards. The Nurses Regulations, 1971 (LI 683) attempts to codify and standardise some nursing practices.[66] However, this 1971 legislation begs review in the light of the current stage of development of the profession in Ghana, vis-à-vis modern best practices. Under Regulation 12(2) of LI 683, for instance, cooking is considered part of the practice of nursing, in addition to serving the patient's food. It may not be fatal to a civil action, such as negligence, that the opinions of a professional body are not sufficiently codified. This is because the courts may rely on the common law to determine civil actions brought under tort or contract. But, as earlier indicated, a criminal charge that is not properly made on a written law is repugnant to the Constitution. Also, the said provisions of Act 857 that seek to hold practitioners criminally liable for not conforming to practice standards may offend the legal principles of fair labelling and legality to the extent that there remains a paucity of codified standards against which the offence must be proved.

Legally, regulatory handouts that purport to enumerate codes of conduct, as well as other institutional policy documents, could not properly be the bases of criminal charges unless they are passed into law. Again, the Constitution requires that any such laws be laid before Parliament.[67] This control is necessary for curtailing the human element of arbitrariness, and for purposes of legislative validation. In principle, once a medical

[65] See Act 857, ss 21(g) and 73(g). Note that this is a criminal offence and is triable in court at the instance of the Attorney-General. This is different from professional misconduct or infamous conduct in a professional respect over which the regulatory bodies have jurisdiction, which is not treated as a crime but a professional wrong, despite that the conduct in question might previously or later be punished as a crime in proper court.

[66] See reg 12(2) of LI 683.

[67] Constitution of Ghana, 1992, Art 11(7).

conduct becomes the subject of crime, it is not left for the professional brethren to determine. This becomes solely the preserve of the court, which may even consider whether or not to admit evidence by the professional body.[68] Perhaps this point is succinctly illustrated by the court in *Sarimbe Alias Olala v. The Republic*[69] in the following dictum: 'in proving death, evidence from the medical officer was desirable but not essential.' Another countervailing observation is that criminalisation of failure to comply with standards is not evenly applied to all professionals identified under Act 857. To criminalise non-compliance by allied health professionals and nurses to the exclusion of other medical professionals under the Act appears to create a bias in favour of other professionals, which potentially amounts to selective justice.

The case involving the HIV-contaminated water[70] remains significant despite proof of the allegation against the suspected doctor. This is so because it provides a clue as to what extent the professional relationship between medical men themselves may be broken. This is also important because of the often-hidden negative effect that such clinical environments may have on the quality of care for the patient.[71] But very importantly, it exposes potential behavioural dispositions of medical professionals toward each other and the interplay between such dispositions and professional self-perception. What is manifested in this case is a situation where a medical professional perceives his fellow professional as capable of lacing his drinking water with HIV-contaminated blood; an act which runs counter to the core mandate of the medical professional, which is to save lives. And this came to be because of a supposed misunderstanding that they had at work. This incident also underlines the possibility that medical professionals in Ghana may as well have negative perception of their own proclivities regarding misconducts and malpractices. However, no existing literature on professional self-perception of medical malpractice in Ghana was found for purposes of review.

Regarding the cases of Dr. Beckley[72] and Dr. Ali-Gabass,[73] it is imperative to assess the medical professional as a natural man with psychosocial vulnerabilities vis-à-vis the professional as a fountain of 'honour and virtue' upon whom society places unfettered faith and confidence. There is a telling anecdotal account that lends support to the idea

[68] See Criminal Offences Act, 1960, s 4(2).
[69] [1984-86] 2 GLR 13-17.
[70] Ibid (n 58).
[71] See S Cullati and others, 'When Team Conflicts Threaten Quality of Care: A Study of Health Care Professionals' Experiences and Perceptions' (2019) 3 Mayo Clin Proc Innov Qual Outcomes 43, 51.
[72] Ibid (n 51).
[73] Ibid (n 55).

that the position of the Ghanaian medical professional is one that generally attracts social prestige. This seamlessly aligns with how medical professionals equally place themselves in society as earlier observed. But this assumed perception of 'nobility,' 'honour' or 'virtue' may occasionally give way to personal vulnerabilities or predilections. The reality is that 'personal demons' must at some point prevail over duty and honour.[74] It is therefore not surprising that a medical professional would bait a minor to forcibly have sexual relations with that person, or that another would kill a person for some sort of ritual. These unfortunate events suffice to explain the reality that there may genuinely exist internal forces with which the professional as a human being may be warring. These forces may include addictions, paraphilias, or mental disorders. It is therefore not enough to merely erase the name of such a medical man from the register of practitioners. It is important to have a dedicated system in place whereby special needs may be identified and addressed before they become real problems. Dr. Ali-Gabass, while in prison, has recently been engaged by the University of Cape Coast as a prisoner-instructor for the university's novel distance education programme at the Nsawam Medium Security Prison.[75] However, this has been met with stern criticisms, and genuinely so, by some members of the medical fraternity, who believe he remains a threat as a sex offender to minor inmates who may come under his tutelage.[76] But beyond sanctions, there is a need for restorative treatment that helps embattled professional men to overcome their 'demons'. This calls for regulatory and institutional commitment. Sadly, there is a dearth of empirical studies in this area in Ghana. In the ordinary Ghanaian clinical setting, there are no dedicated systems or avenues for addressing the psychosocial needs of the health professional himself. Who then cares for the carer? In recognition of this reality, the Korle-Bu Teaching Hospital is reported to have taken a recent initiative to create a rehabilitation unit to address the needs of their staff who battle addictions. This decision was apparently influenced by incidents of abuse of prescription drugs, particularly pethidine, by some medical personnel of the

[74] SS Mehta and ML Edwards, 'Suffering in Silence: Mental Health Stigma and Physicians' Licensing Fears' (2018) 3 American Journal of Psychiatry 11 <https://psychiatryonline.org/doi/10.1176/appi.ajp-rj.2018.131101> accessed 9 September 2021.

[75] P Semevor, 'Engaging Dr Ali Gabass Will Be an Attack on UCC's Reputation – Bono Regional Director of Children Department' <https://www.myjoyonline.com/engaging-dr-ali-gabass-will-be-an-attack-on-uccs-reputation-bono-regional-director-of-children-department/> accessed 7 September, 2021.

[76] Ibid. Also see Yin's work on imprisonment.

facility.[77] Mehta and Edwards[78] recommended a comprehensive programme that recognises the importance of mental health to medical professionals, with particular focus on the training period. They suggested that training curricula should be developed to include programmes that address the mental health of the medical professional as well as enable him to develop coping skills. In the case of Ghana, however, there is a need for empirical inquiry into the situation and to assess the necessity for a bifocal intervention whereby programmes for professional mental health are integrated into both training and practice.

Finally, the stillborn-babies scandal[79] and the baby-harvesting enterprise[80] permeate issues of institutional quality control, political will to maintain integrity of the health system, and professional incentives. First, the idea that a medical professional of a supposed noble repute would pluck new-born babies from their mother for sale is one which, outside considerations of mental health, is shocking and unimaginable. This state of affairs has the potential to kill public confidence in the healthcare system. It also questions the effectiveness of Ghana's health professional training recruitment mechanism. There is yet the question of what policy controls exist for ensuring that such practices do not thrive. The facts of these incidents suggest that these are not random invents. Rather, they may be evidence of a well-integrated practice whose existence thrives on the participation of important members of the patient management team. Indeed, the reports identify doctors and nurses as leading members of the business.[81] Therefore, the necessity to develop and institute a dedicated institutional control mechanism cannot be glossed over, especially given the fact that this is a known phenomenon that has proved to be capable of escalating. The basis of this argument is that a single incident in December 1969 became the subject of a court action when the plaintiff's six-week-old baby who took ill and was admitted at the Apam Catholic Hospital for treatment disappeared without trace.[82] The re-emergence of the phenomenon in its current magnitude is only a testament to the failure of stakeholders to appreciate its reality. Regrettably, it was not after the Komfo Anokye Teaching Hospital incident[83]

[77] JO Brenya, 'Health Workers Abusing Pethidine Drug' <https://centerforhealthjournalism.org/2015/10/09/health-workers-abusing-pethidine-drug> accessed 9 September 2021.
[78] Ibid (n 72).
[79] Ibid (n 56).
[80] Ibid (n 57).
[81] Ibid.
[82] *Asafo v. Catholic Hospital of Apam* [1973] 1 GLR 282-289.
[83] Ibid (n 56).

became public knowledge that other mothers who had suffered similar ordeals at the facility came public about their individual experiences. At least, one thing is certain, that the institution's internal quality control mechanisms alone were not sufficient to uncover such an enterprise within its walls.

The importance of the 2021 exposé, however, is that it demonstrates the need for joint institutional effort in addressing a problem of such magnitude. In this instance, a regulatory authority (MDC) teamed up with a statutory body charged with investigating organised crime (EOCO) and private investigative journalists in a common pursuit of the problem, which is commendable and worth exploring for standardisation and further integration into the healthcare system. Under the auspices of the Ministry of Health, Ghana launched a 5-year National Healthcare Quality Strategy in December 2016 to be implemented over the years spanning 2017 to 2021.[84] The policy document recognised a particular difficulty with accountability for providing quality healthcare in the country.[85] This would explain the incidents under review since mortality audits and reporting are integrated into quality control in the Ghanaian healthcare setup. The point is that a properly audited neonatal death should raise and address questions bordering on the whereabouts of a missing new-born baby. Regarding the teaching hospitals, which serve as model hospitals for the rest of the country, the policy document indicated that only two out of four were reporting performance on quality planning and improvement to the Ministry.

According to the policy document, this situation negated the gains from concerted efforts and ministerial supervision.[86] This is a worrying observation since at least one of such facilities was cited in the missing-babies scandal.[87] The observation also demonstrates a regrettable constraint on the political will to maintain sanctity in the health sector. Lastly, the aspect of professional incentives must be considered. In the 2021 baby-harvesting exposé, a baby was sold for as much as ₵30,000 ($5,000).[88] No sufficient value can be placed on human life, but this amount, compared to the salary of the ordinary Ghanaian doctor or nurse, may be sufficient to entice a medical professional into such an illicit trade. As of 2020, the highest-ranked professional nurse

[84] Ministry of Health, *Ghana National Healthcare Quality Strategy (2017-2021)* (Ministry of Health, Accra 2016) <https://www.moh.gov.gh/wp-content/uploads/2017/06/National20Quality20Strategy20Ghana.pdf> accessed 10 September, 2021.
[85] Ibid.
[86] Ibid.
[87] Ibid (n 56).
[88] Ibid (n 57).

(Nurse Specialist and Consultant) employed by the government was paid about ₵5,527.55 ($921) per month (market premium not included and taxes not exacted).[89] Similarly, the highest-ranked medical doctor (Consultant) was paid about ₵6,325.58 per month.[90] In principle, it would take that professional about 5-6 months to make as much as he stood to make from the sale of one baby. Even before Ghana implemented a Single Spine Salary Structure for government workers, the World Bank had reported on the salary situation of the Ghanaian health worker and had observed an association between low wages and migration of Ghanaian health workers across the country.[91] Akpedzi in a 2019 study reported that the new salary structure had injected some motivation in the Ghanaian health professional; however, he observed that this gain has been eroded by high currency inflation and inadequate working conditions.[92] There is therefore a need for a comprehensive review of the current salary regime.

Negligence as Malpractice

To avert the risk of confusion, it is imperative to set out on a discussion of this subject by attempting to distinguish *negligence* (otherwise referred to as *ordinary negligence* or *negligence simpliciter*) from *medical negligence*. In simple terms, medical negligence is a form of negligence. The two are distinct but their elements are the same.[93] The distinction stems from the fact that medical negligence occurs in the course of a professional-patient relationship, and a claim of medical negligence arises from the exercise of a medical judgement.[94] On the contrary, negligence simpliciter may occur in or outside the course of the professional relationship, but the claim is made on an issue that lies within common knowledge.[95] Thus, although a negligent conduct may occur within a healthcare facility, it may not necessarily warrant a medical negligence claim. In other words, an incident on a hospital premises may occasion a suit in negligence; however, if it did not flow from the exercise of a medical judgement within a professional

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[89] Ministry of Finance and Economic Planning, *2020 Single Spine Salary Structure (As Revised)* (MOFEP, Accra). Note: These figures are not officially published for public consumption.

[90] Ibid.

[91] J Antwi and D Phillips, Wages and Health Worker Retention in Ghana: Evidence from Public Sector Wage Reforms (2012) <https://openknowledge.worldbank.org/bitstream/handle/10986/13581/691070WP00PUBL0GhanaMigrationSalary.pdf?sequence=1> accessed 10 September, 2021.

[92] AK Apedzi, An Assessment of Health Worker's View on the Current Single Spine Pay Policy. A Case Study on Doctors and Nurses in Greater Accra Region, Ghana (2019) 20 BJSTR 15471, 15479 <https://biomedres.us/pdfs/BJSTR.MS.ID.003527.pdf> accessed 10 September 2021.

[93] Ibid (n 8).

[94] *Bryant v. Oakpointe Villa Nursing Ctr.,* 471 Mich. 411, 684 N.W.2d 864 (2004).

[95] Ibid.

relationship, a case may not be made in medical negligence but negligence simpliciter. The importance of this distinction is that medical or expert opinion would not be required to prove negligence simpliciter, since it does not question the use of medical judgement.[96] In such an instance, common knowledge, otherwise known as the reasonable man's standard would be applied. But expert medical opinion is not always necessary for the determination of a matter of medical negligence. There are occasions when the reasonable man's standard may still apply. This would be the case where the alleged negligent conduct is obvious or lies within the realm of a layman's understanding.[97]

Arguably, the most instructive illustrations on negligence are traceable to judicial decisions on the subject. It would therefore be appropriate to consider the relevant propositions. Lord Baron Alderson in the English case of *Blyth v. Birmingham Waterworks Co.*[98] proposed that *'negligence is the omission to do something which a reasonable man, guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or doing something which a prudent and reasonable man would not do.'* Essentially, Lord Alderson was of the view that if a reasonable or prudent person in a similar situation would not have exhibited a conduct in question, then that conduct was negligent. The import of this view is that the conduct in question must be assessed against the standard of a reasonable or prudent person. Bal viewed the reasonable man's standard as a legal fiction created by judges and lawyers to enable the law to have a reference standard of reasoned conduct against which another person's conduct could be measured if he was put in the same situation as the reasonable man.[99] Bannerman thus opined that the reasonable man is a hypothetical person, whose conduct is assumed by the society to be the standard in any given situation.[100] That man could be any person on the *trotro* bus, or the market woman at Kotokuraba. The prudent or reasonable man's standard is, however, not rigid but ambulatory or relative, and its determination depends on the peculiarities or circumstances of a particular conduct and situation. The implication is that there may be varying degrees of prudence, some less, which may still be acceptable in the eyes of the law. In the case of *Adu v. Gliksten West Africa Ltd,*[101] the High Court found a conduct in question to be less prudent yet

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[96] *Grossman v. Barke*, 868 A.2d 561 (2005).
[97] Ibid.
[98] 11 Exch. 78, 156 Eng. Rep. 1047 (1856). (Emphasis added).
[99] Ibid (n 7).
[100] ER Bannerman, 'Negligence—The Reasonable Man and the Application of the Objective Test in Anglo-American Jurisprudence [1969] 2 UGLJ 69, 88.
[101] [1961] GLR 662-665.

reasonable. Justice Apaloo, in delivering his opinion, noted: 'I am satisfied he was in a real dilemma and took a course, which turned out to be less than prudent. But in my judgment, the defendants by their negligence put him in this dilemma and he took a course that was not unreasonable.' In the case of *The Republic v. High Court, Kumasi: Ex Parte Mobil Oil Ghana Ltd,*[102] the Supreme Court of Ghana also took the position that sometimes the court must be seen to personify the reasonable man. Hence, the court's view may be imputed to the reasonable man if a situation is such that the hypothetical person without the benefit of some knowledge or skill would not be able to come to an objective conclusion. The effect of this decision is that the reasonable man's standard could at some point be estimated in the view of the court rather than any hypothetical person. But in all cases, the determination of what the reasonable man would do must be done objectively. This reasoning by the court appears to have been applied in the case of *Asantekramo Alias Kumah v. Attorney-General*,[103] where the court subjected some medical opinion to common logic and in its estimation found that the opinion lacked sufficient logical basis to be accepted by the court.

In the case of *Allasan Kotokoli v. Moro Hausa,*[104] Justice Edusei quoted with approval the following dictum of Lord Wright in the English case of *Lochgelly Iron & Coal Co. Ltd. v. M'Mullan*[105] as to the elements of negligence: 'In strict legal analysis, negligence means more than heedless or careless conduct, whether in omission or commission: it properly connotes the complex concept of *duty, breach, and damage thereby suffered by the person to whom the duty was owing*.' The immediate dictum suggests that in order for a person to succeed in a case of negligence, that person must show that a certain duty was owed him; that there was a breach of that duty; and that he suffered a harm because of that breach. One also gets the impression that negligence does not mean mere carelessness. A duty must be recognised by law, so that not every perceived wrong is actionable in negligence. Accordingly, the English House of Lords has held that there is no duty to treat if it is not in the best interest of the patient so to do.[106] Thus, there may exist a contract of care, but there may not necessarily be a duty of care. Breach of a duty of care arises where a standard of care falls short of that of the reasonable man, or that of a reasonable medical professional in the case of medical negligence. Also, harm must be reasonably foreseeable by a person if the law must hold

[102] Suit No. J5/11/2005. Judgement of the Supreme Court of Ghana, Accra, delivered 13/07/2005.
[103] [1975] 1 GLR 319-357.
[104] [1967] GLR 298-304.
[105] [1934] A.C. 1. (Emphasis added).
[106] *Airedale National Health Service Trust v Bland* [1993] AC 789.

that person liable for causing it. In the English case of *Donoghue v. Stevenson*[107] the court took the view that if one can reasonably foresee or contemplate that a person might suffer some harm by one's conduct, then one owes a duty of care to that person. But, instead of establishing the three essential elements in order to prove negligence (i.e., existence of duty, breach of duty, and resultant harm) a person may only give enough evidence to prove that the other person against whom the action is brought was in control of the situation which caused his injury, and that his injury would not have occurred but for the negligent act of that other person. In doing so, the person suing would be relying on the principle called *res ipsa loquitur*.[108] A successful plea of facts that support *res ipsa loquitur* raises a presumption of negligence against the defendant and a burden is cast on that defendant to offer a sound explanation to show that the harm was not caused by his negligence or that of his servant, failing which he must be held liable.[109] In principle, what the plaintiff would be suggesting to the court is that he has no actual proof for what caused the harm, but since the defendant was in control of the situation from which the harm arose, that defendant should be held liable.

Medical Negligence

To establish liability for medical negligence, a duty of care toward a patient must arise from the professional-patient relationship.[110] In the everyday Ghanaian clinical setting, this relationship comes alive when a person has checked in at the records section, has been triaged or assessed, and a medical professional has accepted or taken charge of the person as a patient. Hence, in the typical Out-Patient Department (OPD) situation, the relationship may start with the triage person when some form of understanding has been established between the professional and the patient. In emergencies, this may take a different form. Since a person in such a situation may lack the capacity to submit himself to the patient role, both the common law and statute may imply this consent. Article 30 of the Constitution thus provides that a person who by reason of sickness or any other cause is unable to give consent shall not be deprived of medical care by reason only of religious or other beliefs. The implication of this provision is that submission to the patient role may be deemed to have been made by an incapacitated person once that person is brought into the emergency room, and some form of obligation is placed on the medical professional to attend to such a person. However, a duty of care in this scenario would depend on the clinical situations of the professional, the facility and that

[107] [1932] AC 562.
[108] Ibid (n 101).
[109] Ibid.
[110] Ibid (n 92).

incapacitated person. The factors may include the availability of the professional and the capacity to treat the person. The professional relationship then begins once the professional takes charge of the incapacitated person. The general rule then is, that medical professionals are not under obligation to enter a professional relationship with a patient unless they choose to, except in some emergency situations where the law imposes an obligation on the professional.[111]

It has already been illustrated that with ordinary negligence, the test or standard of care is that of the reasonable man.[112] But the law places a different standard of care on professionals like medical men. This position of the law was articulated in the judgment of Justice McNair in the English case of *Bolam v. Friern Hospital Management Committee* as follows:

> But where you get a situation which involves the use of some special skill or competence, then the test as to whether there has been negligence or not is not the test of a man on top of a Clapham omnibus, because he has not got this special skill. The test is the standard of the ordinary skilled man exercising and professing to have that special skill…A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art.[113]

The judicial reasoning from the *Bolam* case has come to be known as the Bolam Test or Bolam Principle, and is used to weigh the standard of care expected of professionals such as doctors, nurses, anesthetists, etc. in alleged cases of medical negligence. In a typical medical negligence case, the court would thus determine what the ordinary skilled medical professional would do if he was placed in that same situation. And this would be based on the testimony of his own peers. The legal rationale is that a layman is presumed to lack 'the knowledge to determine the factual issues of medical causation; the degree of skill, knowledge, and experience required; and the breach of the medical standard of care.'[114] The risk to this position of the law, in practice, is that it is possible that expert witnesses may embellish the facts or falsely corroborate evidence in sympathy toward a desperate peer. In recognition of this reality, the English court in

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[111] V Blake, 'Health Law: When is a Patient-Physician Relationship Established' (2012) 14 American Medical Association Journal of Ethics 403, 406 < https://journalofethics.ama-assn.org/article/when-patient-physician-relationship-established/2012-05> accessed 15 September 2021.
[112] Ibid (n 98).
[113] Ibid (n 49).
[114] Ibid (n 94).

Bolitho v. City and Hackney Health Authority[115] took a notable view that if it is proved that a professional opinion is incapable of withstanding logical analysis, a judge is not bound to accept it as representing the opinion of a reasonable body of practitioners. But even before the decision in *Bolitho*, Justice Taylor in the Ghanaian case of *Asantekramo*[116] had already expressed and given effect to that opinion. As did medical men against that decision,[117] it should be expected that the professional brethren would likely treat with contempt an opinion that effectively undermines their view on their own practice. Application of the Bolam Test has further been limited in cases involving the taking of informed consent of the patient prior to implementing clinical decisions. In the recent landmark case of *Montgomery v. Lanarkshire Health Board*,[118] the UK Supreme Court considered a departure from the Bolam Test in a matter that turned on informed consent. The court was of the opinion 'that a departure from the Bolam test will reduce the predictability of the outcome of litigation, given the difficulty of overcoming that test in contested proceedings.'[119] One underlying rationale for this decision appears to be that it is easier to have a corroborating medical opinion for a medical conduct under legal scrutiny. In the instant case, a doctor, who thought the risk was small, failed to tell an expectant mother with diabetes that there was a 9-10% chance of her large baby suffering shoulder dystocia through vaginal delivery. As a result, her baby suffered a disability from this injury. The patient argued that she should have been informed of the risk of vaginal delivery and also that there was the option of caesarean section. The court accepted her argument and in doing so departed from the *Bolam* case which would have required that the decision be made in accordance with medical opinion rather than the opinion of any reasonable man. Effectively, the court also took the position that the significance of a medical risk should not merely be confined to numeral values, but the material value that the patient would place on it. This decision also overturned that of *Sidaway v. Bethlem Royal Hospital*[120] where the House of Lords upheld the Bolam principle and rejected a patient's argument that if she had been told the less-than-2% risk of paralysis, she would have refused surgery.

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[115] [1997] 3 WLR 1151 [HL].

[116] Ibid (n 101).

[117] See G Plange-Rhule, 'Medical Negligence in Ghana – Another Look at Asantekramo' (2013) 2 Postgraduate Medical Journal of Ghana 41, 43.

[118] [2015] UKSC 11; [2015] AC 1430.

[119] Ibid.

[120] [1985] 1 All ER 643.

Finally, in *Willsher v. Essex Area Health Authority*,[121] the court declined to treat a junior doctor differently and held him to the same standard as an ordinarily skilled doctor when he wrongly performed a procedure that led to the partial blindness of a baby. The court ruled that a junior doctor owed the same duty of care as any other qualified doctor and considered that treating the junior doctor differently will mean that the quality of care a patient receives must depend on the experience of the attending professional. This ruling is significant to the extent that it ensures that healthcare facilities provide adequate supervision for professionals who may be less experienced; so that the inexperience of such professionals would not be used as basis to escape legal liability.

Medical Negligence in Ghana

Currently, there are barely a dozen reported court judgments on medical negligence in Ghana. Given the gruesome nature of the few malpractice and misconduct incidents discussed earlier, an empirical inquiry into the scarcity of malpractice suits is patently intriguing. It is apparent, however, that the Ghanaian patient is gradually realising and obtaining the ability to exercise his legal options in matters coming within the subject, and the courts disposition toward such claims are illustrated in the following decisions.

Asafo v. Catholic Hospital of Apam

In *Asafo v. Catholic Hospital of Apam*,[122] the plaintiff's six-weeks-old baby was admitted to a special ward of the defendant's hospital for treatment. Besides mothers, who were periodically allowed entry to breastfeed their babies, the ward was not open to visitors. While on medication rounds one morning, the nurse on duty observed that the baby was missing from her cot and was never found. When the father sued in negligence and sought to rely on *res ipsa loquitur*, the hospital failed to offer a sound explanation for the occurrence. The court reasoned that a child of six weeks old was no different from an inanimate object which was incapable of independent movement but depended on the support of whoever had its custody. In holding the hospital liable for negligence, Justice Edward Wiredu further pointed that by admitting the baby under that circumstance, the hospital assumed the custody and control of the baby and 'became by law duty-bound to ensure the safe custody of her and to deliver her back to the plaintiff whether dead or alive.'[123]

This case touches on the security systems in the Ghanaian hospital and particularly raises a question as to its sufficiency. Indeed, the hospital's lawyer had invited the court

[121] [1988] 1 AC 1074.
[122] Ibid (n 80).
[123] Ibid.

to consider the security situation at the hospital and argued that 'in the absence of any evidence to show that the administrative set up of the defendants' hospital was found wanting in their security system compared with what exists elsewhere in other hospitals, the plaintiff's action should be dismissed.'[124] It would appear that this was a sound argument except that the records did not indicate any evidence being adduced to apprise the court of the sufficiency or parity of the hospital's security structure in comparison with any standardised systems within the country. As the disappearance of a baby is a matter that lies within common knowledge, the *Asafo* case was not decided on expert medical evidence. It was a matter of ordinary negligence despite that the harm was caused in the course of a professional relationship. Healthcare facilities may learn from this case to improve security provisions on their premises. Attention may be paid to visiting hours through monitoring of visitors by both health and security personnel to ensure that such incidents do not occur.

The seemingly pervasive situation where elderly, less experienced persons are retained to provide security must be reviewed and addressed. The instant case also leaves one to consider the patient-monitoring and handing-over duties of nurses. For a typical Ghanaian ward, a nurse who is ending his shift is required to do a patient-by-patient and equipment-by-equipment handing-over to the oncoming nurse. These routines exist to ensure that hospitals keep track of the state of their wards at any point in time. The case report did not suggest that the disappearance of the baby had something to do with shift change. But a proper handing-over routine may help to discover such occurrences early, and perhaps a timely follow-up may lead to the successful resolution of the problem. Also, the case report indicated that the night nurse discovered the disappearance of the baby during her morning medication routine. One may want to know whether or not she was working alone, or what she was doing when the baby disappeared. Since the report does not make any disclosure as to these questions, one is only left to conjecture. It could have been the case that she was running an errand; that she was attending to some other child; or that she was tired and decided to have a rest. These realities make it necessary for facilities to have enough staff on duty to watch over when one has to excuse oneself. On the facts, it is fair to agree with the plaintiff that the circumstances under which his child disappeared were within the exclusive knowledge of the staff on duty at the material time, including security personnel, and that it was proper to hold the hospital to account.

[124] Ibid.

Asantekramo Alias Kumah v. Attorney-General

In the case of *Asantekramo*,[125] a nineteen-year-old woman who was diagnosed with ruptured ectopic pregnancy underwent an urgent surgical operation at the Komfo Anokye Government Hospital. While the surgery was successful, her right arm became swollen and gangrenous after being transfused an amount of blood by the nursing staff through a vein in that arm. To save her life, her arm was amputated. Two years later, the woman sued the State, seeking damages for negligence on the part of the hospital staff. The expert evidence showed that the bacteria that caused the gangrene was either transmitted through the blood transfusion needle or a dextrose infusion administered to the woman. There was also evidence that the blood that was transfused did not properly run through the vein but was stagnant and collected in that arm as a result of a wrong insertion of the needle. The defendant failed to give evidence as to whether the needle and apparatus used were sterilised or that the dextrose infusion and the blood transfusion were free from contamination. The attending nurses were also not called to testify as to how they discharged their duties. This, in the opinion of the court, was crucial to the State's defence. When the attending surgeon was questioned as to how the bacteria entered the woman's body, his opinion was that it was a mystery. To this, Justice Taylor remarked: 'As a court of law and a tribunal dealing with facts, I am afraid, I must have no truck with the mysterious.' In holding the State liable for the negligence of the hospital, the court stated the duty of a hospital to their patient, quoting with approval the dictum of the English court in the case of *Gold v. Essex County Council*:[126]

> Their duty would seem to be to maintain and treat the sick in their hospital, and that appears to me to oblige the defendants, not merely to provide a nurse and treatment, but to provide nursing, which they do and can only do by their servants. If there is negligent nursing I can see no ground on which they can say that they have discharged the duty cast on them.

The court further adopted the view that having accepted the plaintiff as a patient for treatment, it was their duty to treat her with reasonable care. Since the hospital selected, employed and paid the doctors and nurses, and the patient had no say in their selection at all, if those surgeons and nurses did not treat her with proper care and skill, then the hospital authorities must answer for it. First, importance must be attached to the court's observation of the fact that the attending nurses were excluded

[125] Ibid (n 101).

[126] [1942] 2 K.B. 293, C.A.

from testifying or making any sworn statements in respect of the procedure they performed, out of which the supposed negligence arose. Notwithstanding the reason or legal strategy, there is an objective inference as to the confidence reposed in nurses and their ability to provide a sound, independent construction of their own practice. A connection could be drawn from this observation to the political placement of the nurse within the Ghanaian clinical setting. Arguably, this may be associated with the nature of training and conditioning of the Ghanaian nurse.

Until recently, the highest level of professional training for nurses was diploma and no nursing degree programmes were running in the country.[127] But even after the introduction of advanced training in nursing, there appears to persist the phenomenon where the nurse is merely conceived as an ancillary or corollary personnel trained to execute medical orders and where the nurse's opinion or role naturally runs subservient to that of the doctor. To confront this observation adequately would be to wade into an age-old philosophical debate. But perhaps providing some context to this may prompt some clarity. It is documented that the training and practice of the first Ghanaian nurses relied on the expertise, tutelage and control of physicians.[128] Akiwumi paints a historical picture and provides a Ghanaian background in the following words: 'The doctor rewarded the nurse who obeyed his instructions and punished the one who did not with humiliation and even the threat of dismissal. He considered a good nurse as the one who could perform the doctors' tasks best.'[129] This perspective also begs the question as to whether or not the role of the nurse is a delegated function of the doctor. In practice, however, it would appear that the role of either profession is complementary, although the balance of control naturally shifts to the doctor.

Statutorily, regulation 12(2) of LI 683 distinguishes those roles which a nurse may perform independent of a doctor from those that require the doctor's authorization or supervision. The inference is that the Ghanaian nurse is capable of exercising independent clinical judgments and should properly be allowed to account for same if the country is serious about promoting advancement of the profession. Persistence of the phenomenon in its current nature may pose a fetter on the development and recognition

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[127] M Opare and JE Mill, The Evolution of Nursing Education in a Post-Independence Context—Ghana from 1957 to 1970' (2000) 22 Western Journal of Nursing Research 936, 944.

[128] See discussion in A Adu-Gyamfi and E Brenya, 'Nursing in Ghana: A search for Florence Nightingale in an African City' (2016) <https://www.hindawi.com/journals/isrn/2016/9754845/> accessed 18 September 2021.

[129] A Akiwumi, *Higher Education for Nurses (Inter-Faculty Lecture, University of Ghana, Legon, Ghana*, *1970)* (Ghana Universities Press 1971).

of an independent, professional nursing opinion even for purposes of legal scrutiny in such matters as professional malpractice. Secondly, notice must be taken of the fact that the plaintiff filed the suit two years after her experience and judgment were entered six years later. This turnout of events is significant for purposes of documentation and recordkeeping. The nexus is that where there is proper documentation and recordkeeping, a hospital may be better armed in its defence to such malpractice suits.

Finally, the decision in *Asantekramo* has recently been criticised by Plange-Rhule,[130] who argued that the judge failed to appreciate the pathology behind the plaintiff's injury when he suggested that he did not see why a patient reporting stomach pains should go home with an amputated arm. The author also argued that the judge's opinion was erroneous because he incorrectly interpreted medical facts. It was further suggested that there is 'a certain hostility against medical personnel out there when it comes to medical negligence,' therefore such professionals should master the skill of effectively communicating their opinion. The author, however, expressed the view that where a medical professional was truly found negligent, sanctions should apply. In our estimation, these criticisms are important because they manifest the extent of academic freedom and the freedom of speech as enshrined under Article 21 of the Constitution. Indeed, the judiciary is not, and should not, be above criticisms. But the import of the author's argument was that the assessment of medical opinion must unconditionally be left to the medical man. In effect, this was an argument in favour of medical paternalism which must not yield in a country that is mindful of the health rights of its citizens.

As suggested earlier, the fear of predictability in the outcomes of matters turning on medical opinion was one of the reasons behind the *Montgomery*[131] decision in the UK. In any case, the decision in *Asantekramo* was not devoid of medical basis, as the court formed its opinion on two opposing expert arguments. However, the insinuation of hostility against medical personnel may pass for fair comment only to the extent that matters concerning human life may naturally draw judicial sympathy. But we see no sufficient basis for this opinion since the court is very capable of separating sympathy from conviction and would not ordinally act on such sympathy to the miscarriage of justice. In *Gyan v. Ashanti Goldfields Corporation*[132] which we shall discuss next, the court rejected a father's medical negligence claim against a hospital for causing the paralysis of his son. Justice Essiem gave the majority opinion in the following words: 'I have not arrived at my conclusion without some very serious reflections on the plight of

[130] Ibid (n 115).
[131] Ibid (n 116).
[132] [1991] 1 GLR 466-483.

this unfortunate plaintiff. He has my full sympathy but like the trial judge, I hold that sympathy is not a basis upon which a plaintiff should succeed in a court of law.' This dictum exemplifies our reaction to Plange-Rhule's opinion. The Ghanaian court has generally not taken human rights matters lightly and even other matters such as defamation are punished seriously. In *Fodwoo v. Law Chambers*,[133] the Supreme Court of Ghana dealt mercilessly with a law firm that was found to have negligently handled a client's brief. The court held that 'it is in the public interest that professional standards should be closely watched and that lapses in lawyers must be seriously viewed and where, as here, such lapses result in grave financial losses to lay clients, they must be adequately compensated.' This was a 1965 judgment, entered ten years before *Asantekramo*. This decision in addition to recent decisions by the General Legal Council against some lawyers should help diffuse the notion that there is a particular hostility against medical professionals alone in relation to malpractice. It is noteworthy, though, that there is no proportionate public interest in holding public leaders accountable for corruption and political negligence leading to financial loss which also potentially result in poverty and loss of lives. To hold well-meaning professionals to that much account without a commensurate scrutiny over public officials practically creates a situation of double standards. Also, despite judicial disposition toward medical negligence, anecdotal evidence rather suggests public respect and sympathy for medical professionals, and this could account for the scarcity of malpractice suits recorded in the country generally.

Gyan v. Ashanti Goldfields Corporation

Gyan v. Ashanti Goldfields Corporation[134] is another case of medical negligence involving the nurse, which was terminated at the Court of Appeal, Accra. The event from which this case arose occurred in May 1976 when the plaintiff took his one-year-old son to the defendant company's hospital with a complaint of high body temperature. A senior nurse at the OPD who believed that the child's presenting history was suggestive of malaria infection administered a chloroquine injection without prior test or consultation with the doctor on duty. As a result of the injection, the child suffered paralysis of his right leg. It was later confirmed that the child rather had polio and the chloroquine injection complicated the condition thereby causing paralysis. The child's father filed a medical negligence suit, claiming that if a proper diagnosis had been made prior to the treatment, it would have been discovered that the plaintiff was suffering from polio and

[133] [1965] GLR 363-375.
[134] Ibid (n 130).

that the nurse failed to follow laid down regulations when he acted without prior reference to a doctor or laboratory test.

In the alternative the plaintiff relied on the principle of *res ipsa loquitur*. The case report shows that the plaintiff did not give evidence to prove what regulation the nurse failed to comply with. Both the trial court and the Court of Appeal accepted the defendant's explanation that where there was no polio outbreak, incidence of polio was very low when compared to malaria, and that given the high mortality rate in children suffering from malaria, a medical officer would not normally withhold an injection for the treatment of malaria even though there was a small risk of paralysis if it turned out to be polio. The gravamen of the defendant's argument was that had a doctor been informed, he would likely have administered chloroquine, since malaria was a common cause of admission of infants at the material time. As opposed to the *Asantekramo*[135] and *Asafo*[136] cases, the defendants in this case offered an explanation which in the view of the court rebutted the presumption of negligence raised on the plea of *res ipsa loquitur* by the plaintiff. But what if the expert opinion was that a medical doctor would not have administered the same injection in that circumstance? This could have called for a judicial scrutiny of the practice of the nurse in contradistinction to that of the doctor in the prevailing clinical setting.

As of 1976, LI 683 was in force. Regulation 12(2) provides for what treatment a nurse could administer without the instruction or supervision of a doctor. Under the said Regulation, a nurse could make blood films for the diagnosis of malaria but he could not withdraw blood through a hollow needle for same or administer hypodermic, intra-muscular and intravenous injection without the sanction of a doctor. If the plaintiff had raised this in evidence in such a circumstance, perhaps the nurse would have been found negligent; not because another nurse would not have acted similarly, but because the conduct violated a regulation in force. Justice Ofori-Boateng had actually pointed in his dissenting opinion that a person could be found negligent even though there was evidence that he acted in accordance with common practice. The import of this opinion is that, the fact that a thing is common in practice does not make it right in law. But cognisance must be taken of a well-known practice within the Ghanaian clinical setting. It is common to see nurses take medical decisions without necessarily consulting a doctor on the premise of some previously established clinical understanding between the nurse and the doctor. Here, the doctor expressly or tacitly permits certain decisions to be taken on his behalf which he usually affirms on his becoming aware of same. This

[135] Ibid (n 101).
[136] Ibid (n 80).

understanding may develop from cordial professional relationships, familiarity with the practice of the doctor arising from long existing professional relationships, and an attempt to reduce workload on the doctor. It is possible to view the nurse as an agent or servant of the doctor in such a case and the circumstances may suggest that the nurse had obtained some usual or apparent authority to act in that manner. But must it be the case that a nurse or anesthetist can perform an abdominal surgery, for instance, merely because he has learned on the job to perform that procedure, or that a doctor he works with will permit it? As suggested by LI 683, the practice boundaries of the nurse are prescribed by law. This applies to the doctor and other health professionals, in accordance with Act 857.

In *The State v. Kwaku Nkyi*,[137] a student nurse was criminally convicted on the charge of practicing medicine without registration as a medical practitioner under the Medical and Dental Act, 1959, when he administered a drug to a sick child which turned out to be poison and caused the death of that child. From a legal point of view, performing a medical role without the requisite qualification by law is a risk that one may not take, whether or not one is permitted by another who is lawfully qualified to perform that role. This is important, given how contentious malpractice claims could get and how unsettled this area of law is in Ghana. However, the law allows doctors to delegate medical tasks to other professionals who may not be doctors, but in a limited manner. According to Regulation 2 of the LI 1023, a doctor is not to permit an unqualified person to attend, treat or perform operations on patients in respect of matters requiring medical discretion or skill, and where it is imperative to engage the services of paramedics or medical auxiliaries to perform medical roles, that doctor must immediately supervise those personnel. In practice, one-way healthcare facilities have approached this regulation is by developing step-by-step protocols that spell out what nurses or other practitioners could do in particular situations without necessarily consulting the doctor. These protocols are usually posted at vantage areas of the clinic for easy access. To the extent that the regulatory authorities recognise this practice and that no statutory regulations are violated, a nurse or other medical professional may not incur liabilities for following such protocols. The *Gyan* case should extend caution to nurses and other health professionals who would not hesitate to take on medical roles without considering the limits of their own roles.

[137] [1962] 1 GLR 197-199.

Somi v. Tema General Hospital

Somi v. Tema General Hospital[138] was a complaint investigated by the Commission on Human Rights and Administrative Justice (CHRAJ) and determined in the year 2000. In that matter, a pregnant woman was rushed to the OPD of the Tema General Hospital on 4th January, 1998 at about 6.30 a.m., having experienced severe bleeding at home. She was received by the nurse on duty, but there was no doctor to attend to her. The night doctor had left the hospital between 4.00 a.m. and 4.30 a.m. and the doctor who was to take over from her at 8.00 a.m. reported being overly late. Being in an unstable state, an attempt was made by the nurse to resuscitate her. The patient was finally taken to theatre several hours later for a caesarean section, but she died when she was being stitched up in surgery. It was also found that the baby had already died in her womb. The doctor who attended to her attributed the cause of her death to haemorrhage (bleeding). The Commission found on the evidence that the woman had not regularly attended antenatal clinic and that the baby's death was not caused by the delay in receiving medical care. However, the hospital was found to have caused the woman's death by the gross negligence of its staff manifested by the inordinate delay in providing prompt medical attention. Unlike the cases earlier discussed, notice is taken of a receiving nurse in this case who went beyond what duty required to maintain the patient until a doctor arrived. When she noticed that the patient's vital signs (Blood pressure and pulse) were weak and could barely be recorded, she set up an intravenous infusion to resuscitate. She sent a colleague to find the shift driver to go after a doctor but no driver was seen at post. While monitoring, she took some blood samples for grouping and crossmatching to enable her obtain blood in readiness for transfusion orders or surgery. She personally made further attempts to find a driver to go after a doctor. She admitted that she did not refer the patient to the maternity ward because protocol required that the patient be seen by a doctor who would then determine the next cause of intervention. The Commission observed her conduct in the following finding:

> This evidence also reveals that between 4.00 a.m. and 10:00 a.m. when Dr. Forkuo arrived there was no doctor manning the O.P.D. ward. *The nurse was, therefore, compelled to diagnose, prescribe and administer treatment to the patient*, *not to mention the precious time she spent chasing drivers and doctors from their homes*. On these facts, the Commission finds that

[138] (1994-2000) CHRAJ 196; [2000] DLCHRAJ5729

> the Hospital failed to provide the care and attention expected of a public hospital.[139]

The *Somi* case exposes a practice where staff leave the workplace before their shifts end, where others report later than their shifts begin, and where some absent themselves without prior notice. It is not uncommon to find this practice in most Ghanaian institutions, but for a major referral hospital, this was an important observation. Sadly, there is a certain notion of 'Ghana man time (GMT)' which permeates every space of our national life and which appears to glorify the attitude of lateness to scheduled commitments. There is no doubt that addressing such a problem requires a conscious institutional action. The Commission also observed that the hospital had misrepresented the facts as to when the duty doctor had actually arrived, when the surgery was actually performed on the patient, and when her death actually occurred. This conclusion was drawn on the basis that the anaesthetist's record had indicated that the surgery was completed at a later time, which contradicted a statement that showed an earlier time of death on the patient's folder. Also, it observed that the hospital failed to provide record of the patient's condition on arrival, despite that the attending nurse admitted that it was attached to the patient's folder. The Commission thus concluded that the hospital had attempted to conceal vital evidence and further determined that the overall conduct of the hospital amounted to injustice and an unfair treatment of a person by public officers acting in the course of their official duties within the meaning of Article 218(a) of the Constitution. AK Edwin has argued that medical professionals may conceal questionable conducts or medical errors under the pretext of protecting the doctor-patient relationship and the patient, although the underlying motives are generally to avoid loss of reputation and privileges, revocation of license, patient distress and legal liability.[140] Legally, avoiding liability is a natural end of any defendant's conduct. Granted, however, that there was merit to the observation of concealment, it could raise ethical questions and suffice as professional misconduct in itself.[141] AK Edwin was of the opinion that notwithstanding potential punitive implications, failure to disclose medical errors breaches the fiduciary duty of the professional toward his patient and violates a patient-centred ethic.[142] Concealing

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[139] Ibid (Emphasis added).

[140] AK Edwin, Non-Disclosure of Medical Errors an Egregious Violation of Ethical Principles' (2009) 43 Ghana Medical Journal 34, 39.

[141] Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023), reg 12.

[142] Ibid (n 138).

patient records in such a manner could also be punished criminally on the charge of falsification of accounts contrary to section 140 of the Criminal Offences Act, 1960.

The question of concealment and non-disclosure of patient records, particularly on the request of the patient, has been addressed by the High Court of Ghana in the case of *Elizabeth Vaah v. Lister Hospital and Fertility Centre*.[143] The facts as sufficiently quoted by ID Norman and others are as follows:

> On or about the 23-10-2010, the applicant, who was then an expectant mother, began receiving antenatal services from the respondent with a view to delivery at the respondent hospital…Several tests and scans ran on the applicant and the baby proved that she was carrying a healthy fetus and the baby was perfectly normal. On Monday, 08-03-2010, at about 10 p. m., the applicant's membranes ruptured and she was rushed to the respondent hospital without delay. The next day, Tuesday, 09-03-2010, at about 3:30 p. m., the applicant gave birth to a fresh still-birth baby. A post mortem examination revealed that the applicant's baby died of "multiple organ hemorrhages most probably due to a bleeding diathesis/coagulation defect with the bleeding precipitated by 'trauma' of labor (child birth)'. From the post-mortem report, the pathologist is not completely sure what caused the multiple organ hemorrhages. Applicant plans on having another baby in the future and wishes to put at the disposal of any doctor who attends to her, whether in or outside of Ghana, her entire medical records. She, therefore, wished to have access to her medical records at the respondent hospital in order to have complete information on her health status. She, accordingly, caused her solicitors to write to the respondent for a copy of her medical records upon payment of reasonable fees for production of the copies. The respondent acknowledged the applicant's right to the records and indicated that, under normal circumstance, they would have given the report out but it is unwilling to do so because the applicant has [sic] spoken in public media about the circumstances in which she gave birth at the respondent hospital. The respondent, therefore, wrote to the applicant informing her

[143] Ibid (n 10).

> that it will only give out the records when compelled by a court or on the orders of the Medical and Dental Council.[144]

The authors admitted that the court was right in ruling that the patient had the right to her medical records despite disclosing the circumstances of her delivery at the respondent hospital to the media and also that it was not only by the order of the court or the MDC that she should obtain those records. They, however, criticised the legal basis of the court's decision, to wit, that the judge acted out of judicial activism and misapplied common law precedents; and erred when he ruled that the patient had a right to her medical record under Article 21 (1)(f) of the Constitution. In their view, the judge could have ordered the release of the records on the basis of the Physician-Patient rubric; the Medical and Dental Council's Guiding Rules on Disclosure; the Ghana Health Service's Patient Charter of 2010; the Professional Ethics of medical doctors in Ghana; or by merely issuing a subpoena for the records as the time was not appropriate to import a foreign standard that places a duty on medical practitioners to protect patient records and to disclose same to the patient or their legal representative on demand.[145]

We are inclined to disagree with all grounds of the authors' arguments with a few notes of exception. The fundamental human rights under the 1992 Constitution of Ghana are essentially personal or private. To suggest therefore that a medical record on a particular person was private and for that matter did come within a law that guarantees that person's right to information amounts to an obfuscation of the law. If the records were sought by a third party without lawful authorisation, our position would have differed. Again, to suggest that judicial activism in the context of that case was wrong shows an under appreciation of the role of the judge in the development of the law and the protection of minority rights. Perhaps Lord Denning is the most celebrated judge in the history of the common law, and this would substantially be as a result of his judicial activism. Through judicial activism, the South African Constitutional Court in the case of *Minister of Health v. Treatment Action Campaign (No 2)*[146] ruled that the anti-retroviral drug Nevirapine must be made available to the general public to protect children. This judgment arose from an appeal against a trial court's finding that the government had

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[144] ID Norman and others, The Constitutional Mandate for Judge-Made-Law and Judicial Activism: A Case Study of the Matter of Elizabeth Vaah v. Lister Hospital and Fertility Centre (2012) 6 The Open Ethics Journal 1, 7. Note: An attempt was made to obtain a copy of the judgment from the General Jurisdictions registry of the High Court, Accra, sometime in October 2020, but the registry could not retrieve it. My discussion of the judgment therefore relies on the references made by the authors cited.

[145] Ibid.

[146] (CCT8/02) [2002] ZACC 15.

acted unreasonably in (a) refusing to make the drug available in the public health sector where an attending doctor considered it medically indicated; and (b) not rolling out a national programme to prevent mother-to-child transmission of HIV at a time when the spread of the infection posed significant risk to especially the poor minority.

In Ghana, the case of *Re Akoto*[147] was a sad exemplification of a legal system devoid of judicial activism in which the right to personal liberty was crucified in the hallows of judicial inaction. To the extent that no overriding constitutional rights were infringed, the decision in *Vaah* should be considered a positive milestone for the development of medical law in Ghana. We would therefore agree with Lord Denning when he argues that the fact that a judicial decision would not yield to precedent does not mean that such a decision must not be taken. Denning could not be wrong when he held as follows: '[I]f we never do anything which has not been done before we shall never get anywhere. The law will stand still whilst the rest of the whole world goes on. That will be bad for both.'[148] In our belief, the argument by ID Norman and others[149] that the court should have waited for an opportune time to make such a ruling must yield to this ideal. But, perhaps, an important exception to the right of patients to their own medical records could be the non-availability of the record itself. We advance this argument cautiously on the premise that there may be genuine cases where a particular record may not exist or may be lost. It is humanly possible given the workload and resource constraints on the Ghanaian hospital. As footnoted earlier, we could not retrieve a copy of the judgement on this particular case from the court's registry because an attendant could not find it. This does not suggest that someone had made a conscious effort to conceal it. But how do we draw the line between genuine non-availability, conscious concealment, and failure of duty to maintain records? Even with careful legal scrutiny, this may be difficult to determine. This reality ought to be considered when both regulatory and judicial authorities apply their powers to such matters.

Ethically, there may also be grounds to withhold medical information to a patient when doing otherwise might lead to some significant harm to that patient, but that should not justify a total denial of the patient's medical information. If the respondent hospital in the *Vaah* case was aggrieved by the court's decision, it could have sought interpretation of Article 21(1)(f) at the Supreme Court with leave of the Court of Appeal. This would have brought some finality to the matter. Under contract law, the High Court could also have held that there was an implied term for the doctor to disclose the record of the

[147] [1961] GLR 523.
[148] *Parker v. Parker* (1954) All ER 22.
[149] Ibid (n 142).

patient on demand. Suffice to also argue that the disclosure by a patient of his own experience at a hospital to the media should not be a determinant for the release of that patient's medical information to him. The right to free speech is guaranteed under Article 21 of the Constitution. But if that patient's disclosure were untrue or maliciously calculated to affect the reputation or business of the respondent hospital, the hospital could have made a case in court under the tort of injurious falsehood or defamation.

We have earlier suggested that regulatory guidelines or standards issued by regulatory bodies are not automatic sources of law in Ghana. Article 11 of the Constitution outlines the sources of law to which Ghanaian judges may apply themselves in the determination of matters before them. For Medical or Healthcare Law purposes, the relevant sources are cited in the following table.

Table 1: Sources of Medical/Healthcare Law in Ghana

Source of Law	**Examples**
The 1992 Constitution of Ghana.[150]	-
Enactments made by Parliament.[151]	Children's Act, 1998 (ACT 560) as amended by the Children's (Amendment) Act, 2016 (Act 937); Data Protection Act, 2012 (Act 125); Ghana Aids Commission Act, 2016 (Act 938); Ghana Health Service & Teaching Hospitals Act, 1996 (Act 525); Health Professions Regulatory Bodies Act, 2013 (Act 857); Mental Health Act, 2012 (Act 846); Imposition of Restrictions Act, 2020 (Act 1012); Labour Act 2003 (Act 651);

[150] 1992 Constitution of Ghana, Art 1(2) and 11(1).

[151] These may include international treaties, agreements and conventions ratified by Parliament through the passage of Acts or Resolutions in accordance with Article 75 of the 1992 of Ghana.

	Mortuaries & Funeral Facilities Act, 1998 (Act 563); National Health Insurance Act, 2003 (Act 650); Public Health Act, 2012 (Act 851); Right to Information Act, 2019 (Act 989); Specialist Health Training and Plant Medicine Research Act, 2011 (Act 833); Traditional Medicine Practice Act, 2000 (Act 575).
Enactments made under the authority of Parliament (subsidiary/delegated legislation).[152]	Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023); Nurses Regulations, 1971 (LI 683).[153]
Existing law	Criminal Offences Act, 1960 (Act 29); Coroners Act, 1960 (Act 18); Anatomy Act, 1965 (Act 280).
Common law	Principles from decided cases such as *Asafo v. Catholic Hospital of Apam* [1973] 1 GLR 282-289 and *Bolam v. Friern Hospital Management Committee* [1957] 1 WLR 582.

For the guidelines or standards of regulatory authorities to obtain the force of law under the 1992 Constitution, they must be laid before parliament and published in the national

[152] Under the Health Professions Regulatory Bodies Act, 2013 (Act 857), Parliament has empowered the Minister of Health to draw up regulations (acting on the advice of regulatory authorities) for parliamentary approval. The regulatory authorities are the NMC, MDC, Pharmacy Council, Allied Health Council and the Psychology Council.

[153] According to Article 11(4) of the 1992 Constitution, these two examples may properly be considered existing laws for the fact that they were not enacted under the 1992 Constitution per se but under a previous Constitution or military regime.

Gazette on the day they are so laid. Such regulations become ripe for judicial recognition after 21 parliamentary sitting days.[154] ID Norman and others had argued that rather than relying on a common law authority, the court in the *Vaah* case should have relied on a Physician-Patient rubric; the Medical and Dental Council's Guiding Rules on Disclosure; the Ghana Health Service's Patient Charter of 2010; or the Professional Ethics of medical doctors in Ghana.[155] If it was the case that any of those references had the force of law within the meaning of Article 11 of the Constitution and was relevant to the issue before the court, perhaps the judge should have taken judicial notice of them. However, it was not until 2012 that the Patient Charter was integrated into the Public Health Bill and passed into Law.[156] In any case, a Ghana Health Service Patient Charter, which applied to a public agency, may not have applied to the respondent's private facility. Also, the existing regulations on medical ethics (LI 1023) only appeared to provide some aid to the determination of matters bordering on confidentiality of patient information in relation to third parties and not the release of such records to patients themselves. The relevant provision in LI 1023 is as follows:

> It is against professional conduct for a practitioner to disclose voluntarily without the consent of the patient, information that he has obtained in the course of his professional relationship with the patient. (2) A practitioner may, however, disclose such information in the public interest, and shall make such disclosure when required to do so by statute or a court of law.[157]

It would seem that the court in the *Vaah* case could not have relied on this provision to order the release of the applicant's medical record, even though the provision may imply a right of access to the patient's own medical information. Doing so would have robbed the court of the opportunity to pronounce on the human rights aspect of the matter. To avoid the human rights aspect is to banish the issue of access to one's own medical information to the penumbras of contract law and the dominium of ethics. Also, since the Constitution recognises the common law, the court could not have erred in coming

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[154] 1992 Constitution of Ghana, Art 11(7).

[155] Ibid (n 142).

[156] See Public Health Act, 2012 (Act 851), s 167. The Patient Charter is a statutory statement of the rights and duties of the Ghanaian patient. Pertaining to access to patient's own medical information, Clause 2 of the Charter provides: '*The patient is entitled to full information on the patient's 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.' (Emphasis added).

[157] Medical Profession (Professional Conduct and Ethics) Regulations, 1975 (LI 1023), reg 4. (Emphasis added).

under the persuasion of one of two opposing common law positions if it was fair and just to do so. But there are jurisprudential justifications for the recognition of regulatory handouts that have not been properly enacted or legally validated. RM Dworkin had posited that properly enacted rules cannot exhaust law, because we cannot pass laws to cover all human behaviour. Accordingly, where there are no previously existing rules (laws), there are principles on which the courts may fall. And where principles fail, the courts may apply policies.[158] Ethical principles guiding medical practice are not written law, unless they have been enacted as such. The same argument may apply to regulatory guidelines or policies. But the courts may call in aid those principles or policies that have not been legally validated in the determination of matters where circumstances necessitate. A case in point is *Frank Darko v. Korle-Bu Teaching Hospital*[159] where the court relied on ethical principles from the Hippocratic Oath in holding the defendant hospital liable for refusing the plaintiff medical care. Under Act 857, the exercise of regulatory power is done through the enactment and administration of legislative instruments under the hand of the Minister, subject to parliamentary approval.[160] We speak of the power to determine standards for practice and rules for the discipline of practitioners. This power is different from the exercise of advisory or administrative authority under the same Act, considering that the advisory or administrative authority is not necessarily conditioned on enacting regulations.[161] Suffice to argue that even if regulatory authorities had the discretion to make rules without reference to parliament, the exercise of such power would not be absolute but circumscribed by fairness and due process.[162] By way of emphasis, reference may be made to the Ghana Health Service as a public healthcare provider. Section 54 of the Ghana Health Service & Teaching Hospitals Act, 1996 (Act 525) provides as follows:

> (1) The Minister, on the recommendations of the Council or a Teaching Hospital Board may *by legislative instrument make such regulations* as

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[158] RM Dworkin, 'The Model of Rules,' (1967) 35 U Chi L Rev <https://chicagounbound.uchicago.edu/uclrev/vol35/iss1/3> accessed 23 September, 2021.

[159] Suit No. AHR 44/06. Unreported judgment of the Accra Fast Track High Court dated 24/06/2008. See discussion in E Owusu-Dapaa, 'An Inquiry into the Emergence of Health Care Law in England and Wales as a Distinct Body of Law - What Lessons Can be Drawn From this in Relation to Ghana?' (D Phil thesis, Lancaster University 2016) <https://eprints.lancs.ac.uk/id/eprint/79754/1/2016_Ernest_Owusu_Dapaa_PhD_.pdf> accessed 2 August 2021.

[160] See Act 857, ss 49, 74, and 111.

[161] See *Ransford France v. Electoral Commission & Attorney-General*. Suit No. J1/19/ 2012. Unreported Judgement of the Supreme Court of Ghana, Accra dated 19/10/2012.

[162] Ibid; 1992 Constitution of Ghana, Art 296.

> he considers necessary for giving effect to the provisions of this Act. (2) Without limiting subsection (1) of this section regulations may as applicable provide for— (a) procedure for disciplinary action including offences and penalties… (Emphasis added).

Notwithstanding the provision quoted above, the Ghana Health Service issued a document titled the 'Ghana Health Service Code of Conduct and Disciplinary Procedures' in 2018 under the hand of the Director-General of the Service without going through the process of parliamentary approval as required under Section 54 of Act 525. This is obvious because the document was not issued as a legislative instrument. Essentially, the document purports to provide a code of conduct and procedure for the discipline of staff of the Service.[163] Assuming that an issue arises from its implementation, a court may be led to determine the legal validity of the document itself. It is possible, for instance, that a court may declare the document invalid or a provision in question unlawful if it offends a constitutionally protected right of staff of the Service, or if the execution of the said document offends due process. This argument is not advanced to question the legality of the said document per se, but to illustrate the position that not all regulatory handouts or guidelines may be valid in law.

Frank Darko (Minor) (Suing Per Next Friend Gladys Darko, Mother) v. Korle-Bu Teaching Hospital

Frank Darko v. Korle-Bu Teaching Hospital as discussed by Owusu-Dapaa[164] presents a compelling set of facts. In that case, a young boy reported for treatment at the defendant hospital with a history of pain in his right knee, which on assessment was diagnosed as torn patella ligament. He was requested to sign a consent form to allow a surgical repair of that ligament. The statement of consent on the form was reproduced as follows:

> I _hereby consent to undergo the operation of the repair of right patella tendon the effect and nature of which has been explained to me. I also consent to such further or alternative operative measures as may be found to be necessary during the course of such operation and to the

[163] Ghana Health Service, *Ghana Health Service Code of Conduct and Disciplinary Procedures* (GHS, Accra 2018) <https://www.ghanahealthservice.org/downloads/GHS_Code_of_Conduct_and_Disciplinary_Procedures_2018.pdf> accessed 20 September 2020.

[164] Ibid (n 157).

> administration of a local or other anaesthetic for the purpose of the same. I understand an assurance has not been given that the operation will be performed by a particular surgeon.[165]

It would appear that the nature of the consent form quoted above is a replica of that used in most public hospitals in Ghana. As reported, the court adopted the *Bolam* principle and found that the hospital had not been negligent when the left knee was rather operated on. It was observed by the court that the patient had signed a broad consent form which empowered the surgical team to take any necessary measures for the purpose of the operation. Accordingly, if there was a medically justifiable indication for the operation of the left knee, the hospital could not be found negligent for treating it. The court also pointed out the failure of the plaintiff's lawyer to advance arguments on the scope of the consent given vis-à-vis the medical complaint reported by the boy. However, the hospital was found in breach of its duty to provide the boy care when it refused to honour his review and physiotherapy appointments during the pendency of the suit as a protest to his legal action.[166]

Owusu-Dapaa has criticised the court for failing to give weight to the patient's autonomy when it affirmed the broad effect of the consent form.[167] Without the benefit of the full judgment, we do not intend to advance arguments on the decision of the court or the position of Owusu-Dapaa per se. However, the medical realities underlining such cases in Ghana ought to be discussed. According to the World Health Organization (WHO), Ghana had only 3,236 medical doctors as of 2019, amounting to a doctor-to-patient ratio of 1.06 per 10,000 population. Although the number of trained doctors improved from 2,857 in 2018, the doctor-to-patient ratio actually fell from 1.96 per 10,000 population due to population growth.[168] In the same 2018, the United States of America recorded a doctor-to-patient ratio of 26.04 per 10,000 population. Meanwhile, the United Kingdom had recorded a ratio of 56.16 per 10,000 population.[169] In respect of nursing and midwifery staff, Ghana had a ratio of 45.52 per 10,000 population in 2018 but fell to 27.11 in 2019 as a result of population increase. Comparatively, the United

[165] Ibid.
[166] Ibid.
[167] Ibid.
[168] World Health Organization, 'The 2021 update, Global Health Workforce Statistics' (2021) <https://www.who.int/data/gho/data/themes/topics/health-workforce> accessed 25 October 2021.
[169] Ibid.

Kingdom had improved from 81.72 to 102.9 per 10,000 population from the year 2018 to 2019, and the United States had recorded 156.9 per 10,000 population in 2018.[170]

The WHO had indicated that in order to achieve a minimum satisfactory level of healthcare, a country needed to achieve a ratio of 2.5 per 10,000 population for health professionals such as doctors, nurses and midwives.[171] Records from the WHO database indicate that Ghana has never achieved this ratio for doctors since 2004 when the organization began collecting such data on the country, and the figures for nurses and midwives are patently insignificant when compared to those for the United States of America and the United Kingdom. This reality, coupled with lack of infrastructure and incentives for medical care, creates a unique context that makes it difficult to hold the Ghanaian medical professional to certain best practices and standards applicable to the developed world. In the ideal context of a contract of care, a patient should be able to decide who should perform a surgical operation on him. If the consent was for a particular medical decision or procedure, this should be secured under the contract and under patient autonomy. The patient should also be able to seek certain assurances or guarantees from a caregiver with respect to the success of a procedure within that same contract of care. It would appear that a recognition of this ideal would make the nature of consent form used in the case of *Frank Darko*[172] and those generally used in healthcare facilities in the country legally unsuitable. In *Eyre v. Measday*[173] an English court ruled that if a patient needed an express warranty or guarantee of success regarding a procedure, that patient could ask for it. The case illustrates the fact the professional relationship ordinarily arises out of contract on the basis of which a patient could lawfully demand certain obligations from the medical professional. But in the typical Ghanaian hospital where some medical specialties may not be sufficiently available, it may be difficult to encourage a practice whereby patients could choose between professionals. This is not to say that they may not know the identity of professionals who are scheduled to attend to them. Indeed, the Patient's Charter provides that a patient is entitled to know the identity of his caregiver.[174] Diagnostic challenges and lack

[170] Ibid. Note: Figures for the United States had not been published for the year 2019.
[171] World Health Organization, *The World Health Report: 2006: Working Together for Health*. (World Health Organization 2006). <https://apps.who.int/iris/handle/10665/43432> accessed 25 October 2021.
[172] Ibid (n 157).
[173] [1986] 1 All ER 488.
[174] Public Health Act, 2012, (Act 851) s 167.

of ideal equipment may also make it inappropriate to offer certain levels of guarantee as to surgical outcomes.

These realities may explain why a consent form would be drafted in the manner quoted. It is therefore likely that public policy considerations may underlie a court's decision on the propriety of such consent forms. But if a medical professional had entered a contract of care giving specific assurances to a patient, it should fairly be the case that that professional be held to account for that assurance. In *Amakom Sawmill & Co. v. Mansah,*[175] the Supreme Court of Ghana made a notable ruling that even where a person has consented to the risk of some harm, he could not be said either by implication or otherwise to have consented to harm by negligence. It would therefore be wrong in law to assume that a patient should not sue for negligence arising from a medical treatment simply because that person consented to the risks associated with that treatment. The point is that when counting the risks associated with a particular medical procedure, negligence is not included. Also, unless in the exigencies of a particular situation a patient's consent could not be sought, medical professionals must aspire to respect the autonomy of their patients. This principle was succinctly put by an English court in the following words: 'Every human being of adult years and sound mind has a right to determine what shall be done to his own body; and a surgeon who performs an operation without his patient's consent, commits an assault.'[176] In tort, such a bodily violation without prior consent should amount to trespass.

Finally, it is in the interest of public policy that a hospital should not unreasonably deny a person admission to their care. Not too long ago, there emerged a strong public opinion against a phenomenon that has come to be known as 'No Bed Syndrome' whereby persons in emergency situations are commonly turned away by Ghanaian hospitals on the basis of lack of patient beds. Without pretending to be oblivious of the actual underlying challenges, the situation where professionals are more amenable to reject persons in need of medical care must be discouraged. The courts have recognised the true character of a hospital to be that it opens its doors without discrimination and offers its services 'at the call of the afflicted, without scrutiny of the character or the worth of those who appeal to it, looking at nothing and caring for nothing beyond the fact of their affliction.'[177] In our estimation, this ideal should be the basis upon which any

[175] [1963] 1 GLR 368-37.
[176] *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914).
[177] Ibid.

court should hold the hospital in the *Frank Darko*[178] case liable for refusing the plaintiff's care.

Edward Kofi Ghunney v. Justina Ansah and Attorney-General

In 2019, the Accra High Court had the occasion to lay precedent on a matter novel to the courts of Ghana within the area of medical law. *Ghunney v. Justina Ansah and Attorney-General*[179] tackled an aspect of confidentiality of patient information and consent for disclosure of same. The plaintiff, a driver of the Korle-Bu Teaching Hospital where the National Blood Service is situated, sued the Director of the Service and the hospital for defamation and negligence. The plaintiff had gone to donate blood when a test of his blood sample showed that he was HIV positive. The evidence indicated that the Director, who was also a doctor, had informed the plaintiff of his HIV status and further suggested rudely and judgmentally to him that he had contracted the virus from indiscriminate sex. When the plaintiff doubted the result, she challenged him to undergo a confirmatory test on two successive occasions, both of which yielded negative results. The plaintiff also alleged that the Director had informed other persons of his positive status as a result of which he was shunned by his colleagues, but this was not proved. For this reason, the claims founded on defamation were rejected by the court. The court, however, found the Director liable in negligence and ruled that she owed a duty of care not to have disclosed the result to the plaintiff and in the manner she did. It was further found that the Director breached her duty of care when she led the plaintiff to undergo further confirmatory tests. One basis for the court's decision was that the blood donation form, which the plaintiff was made to sign before donating, had a non-disclosure clause, namely, 'I am not donating to know my HIV status.' Also, the defendant's own witness disclosed the practice of the Service that where donated blood was HIV contaminated, it was discarded in accordance with standard procedure without reference to the patient. The court's opinion therefore appears to establish the precedent that since the purpose of blood donation is not to know a donor's HIV status, a medical professional has no right to disclose same to a donor unless otherwise agreed. Regarding the claim on defamation, the court quoted with approval the dictum of Justice Twumasi in the case of *Amoako v. Takoradi Timbers Ltd*[180] as follows:

> A communication between two persons defamatory of another was not actionable if the person making the communication had an interest in the matter so communicated or had a duty, legal, moral, or social to make

[178] Ibid (n 157).
[179] (2019) JELR 67940 (HC).
[180] [1982-83] GLR 69.

> the communication and the person receiving it had a corresponding interest or duty to receive it.

It may be inferred from the quoted opinion that for a disclosure of confidential information to third parties not to constitute defamation, there must have been some social, moral or legal justification for it. Otherwise, the defendant must have had some legitimate interest to protect by the disclosure. As this relates to health, it would be expected that the nature of interest justifying a disclosure would be health related. A disclosure premised on protecting personal interest comes under qualified privilege, which is considered a good defence for defamation; but this must be made in good faith, without malice.[181] Therefore, it is possible that a court may not find a medical professional liable in defamation if he disclosed to his own daughter that a man, she intended to have sexual affair with was a patient of his with an incurable or dangerous sexually transmitted disease.

A case of interest is *Tarasoff v. Regents of University of California*,[182] where the United States Supreme Court ruled that a doctor or psychotherapist is under a legal duty to warn a third party if in the exercise of his professional skill and knowledge, he finds that such a warning is essential to avert a danger arising from a medical or psychological condition of his patient. The legal effect of this rule is that there is the obligation to warn third parties, if it is reasonably foreseeable that a patient might be of some danger to them. A medical professional may therefore not be liable for a disclosure of confidential information under such a situation. It is possible that he may rather be liable for failure to warn. Section 22 of the Act 29 imposes a duty on a person in Ghana to use reasonable means to prevent another from committing a crime if it is known that that other person has designed to commit, or is actually committing, that crime.

Under Section 1 of the Domestic Violence Act, 2007 (Act 732), if a person knows he has HIV or other sexually transmitted disease and has sex with another without prior informing that other person, he commits the crime of domestic violence. When these two provisions are read together, one may come to a conclusion similar to that of the *Tarasoff* case. For professional guidance, and in the interest of justice, the Public Health Act, 2012 (Act 851) has stated the current position of the law on confidentially of patient information. Section 167 of Act 851, which provides the Patient Charter, expressly states that a patient's confidential information shall not be disclosed to third parties without the consent of that patient or the lawful representative of that patient,

[181] Ibid.

[182] 17 Cal. 3d 425 (Cal. 1976).

except where the information is required by law or is in the public interest. This is replicated in Section 60 of the Mental Health Act, 2012 (Act 846) which provides that a person entrusted with confidential information concerning a mentally challenged individual cannot not disclose that information to third parties without written consent from that individual or his lawful representative unless in situations where there is a risk of imminent danger to another person or where the disclosure is required by law. There is no doubt that the principle remains the same. We have earlier pointed out that under the Medical Profession (Professional Conduct and Ethics) Regulations, 1975, a practitioner could only disclose medical information acquired from the professional relationship to third parties in the public interest when so required by statute or a court of law.[183]

Chinbuah v. Attorney-General

In a judgment entered on 21 July 2021, the Accra High Court addressed a matter that turned predominantly on patient autonomy. The case was *Chinbuah v. Attorney-General*[184] in which the court found that the medical team who attended to a pregnant woman ignored her wish to be delivered of her baby by caesarean section. The team rather induced her labour, which caused her to have a traumatic delivery resulting in her having a deformed baby and suffering a vaginal tear from which she bled to death. The plaintiffs, who were the father and husband of the deceased, sued the defendants for medical negligence. In its defence, the hospital argued that the medical team took the decision to induce labour for vaginal delivery because they considered the option best for the patient. It however failed to justify why the caesarean section could not be done in respect of the wishes of the patient. The court also found that the defendant had been negligent in not monitoring the patient properly as a result of which her vaginal tear could not be detected early, and not transfusing the patient to manage the bleeding when blood had been ordered and made available. To better appreciate the underlying legal and ethical issues of this case, it is important to also recount the case of *Dr. Sandys Arthur v. The Ghana Medical Council*.[185] The patient in that case reported at the Christian Medical Centre, Nungua with pains in the upper calf of his left leg, which the doctor in charge diagnosed as torn ligament. The patient's fiancée, who had accompanied him to the clinic, then suggested to the doctor that he could not possibly tear a ligament as he had been in bed and had not engaged in any strenuous activity since his previous week's visit to the clinic. When she suggested on several occasions to the doctor to

[183] Ibid (n 155).
[184] Suit No. GJ/378/2021. Unreported judgment of the Accra High Court dated 21 July 2021.
[185] Ibid (n 16).

consider diagnosing Deep Vein Thrombosis (DVT), her concern was ignored, even up to the point when the patient's leg began to swell with intense pain and later, when he collapsed. After resuscitating him to consciousness, the doctor discharged the patient to report the following day to see a physiotherapist for the torn ligament to be treated, but he died before he could return for the scheduled treatment. When the fiancée filed a complaint at the MDC, the Disciplinary Committee found evidence that the doctor negligently misdiagnosed the patient and should have considered DVT under the circumstances. This was affirmed by the Court of Appeal. These two cases invoke questions of professional duty, ethics and the patient's right to healthcare.

Traditionally, the approach to medical practice across the globe has generally been paternalistic. Although a doctor had a duty to act in the best interest of his patient, it was the doctor, rather than the patient, who decided what that best interest was,[186] because the doctor was presumed to have superior knowledge of his own practice and the patient's condition. Perhaps due to high illiteracy rate and the relatively sluggish pace of modernisation of healthcare in Ghana, this approach to resolving ethical issues remains pervasive. But as the social conditions of Ghanaians improve, the Ghanaian patient is gradually becoming exposed and more aware of his healthcare rights and options. This phenomenal shift is evidenced by the quality of emerging malpractice complaints filed against Ghanaian medical professionals in recent years.

Unlike before, plaintiffs and complainants in recent cases have raised more insightful issues against the clinical judgment of medical professionals in a manner that only suggests an increase in knowledge and awareness of the practice of the medical man. It is evident that the patient in the *Chinbuah* case had a fair appreciation of her delivery options, for which reason she insisted on delivery by caesarean section. Similarly, the fiancée in the *Dr. Sandys Arthur* case showed a better appreciation of the patient's condition than the attending doctor, who had 34 years of experience. Indeed, there is a case pending before the High Court, Accra in which the husband of a deceased patient has sued the Greater Accra Regional Hospital for negligently failing to administer a prophylactic anticoagulant as a result of which her wife died from the complication of thromboembolism following a caesarean section.[187] The implication of this phenomenon

[186] E Jackson, Medical Law: Text, Cases and Materials (4th edn OUP 2016) 2.

[187] *Mohammed Mustapha v. Attorney-General & Minister for Justice*, Suit No. GJ/1043/2020. Writ issued on 8 June 2020. Note: In accordance with Article 88(5) of the 1992 Constitution, the Attorney-General is the nominal defendant in civil actions filed against the State and its agencies. The Greater Accra Regional Hospital is a branch of the Ghana Health Service, and the Service is an agency of the Ministry of Health.

is that medical professionals in Ghana must not be too eager to adopt a paternalistic approach to ethical dilemmas and patient care generally, but must respect the autonomy of the patient as the case may require. For practice guidance, the Patient Charter now provides that 'in all health care activities the patient's dignity and interest must be paramount.'[188] Pertaining to children, the law requires that the best interest of the child be given primary consideration by 'any court, person, institution or other body in any matter' concerning a child.[189] Clinically, this position of the law does not remove potential ethical dilemmas since the opinion of a parent and that of a medical professional might conflict as to what is a child's best interest. The practitioner may therefore find it necessary to resort to court at some point for a judicial determination of some matters.

Criminal Malpractice in Ghana

It is rudimentary to criminal law that for a person to be convicted of a criminal offence, he must have formed a criminal intent (*mens rea*) in addition to committing the criminal act (*actus reus*). Given this premise, it would seem impossible to convict a medical practitioner who had acted in good faith as a result of which a patient was harmed, assuming the preferred charge was not a strict liability offence which does not require proof of criminal intent. But Act 29 defines intent in a manner that makes such a conviction possible. According to Section 11(3) of Act 29, if a person acted such that, if reasonable caution was used, it would occur to that person that the act would probably cause, contribute to cause, or pose a great risk of causing harm, then an intent is to be inferred. Criminal malpractice may assume many forms under the laws of Ghana, but offences in this cluster are not confined to one statute. Under Act 857, it is a criminal offence to wilfully and falsely use a professional title; practice without prior registration, or with expired or suspended registration; practice in an unauthorised facility; or engage the services of unqualified persons in one's practice.[190] Professionals who are convicted of any of these crimes stand to pay a fine, with or without prison term.[191] For allied health personnel and nurses, failure to conform to professional practice standards is a criminal offence, and persons who are found culpable similarly stand to pay a fine, with or without prison term.[192] Also, nurses, allied health personnel and psychologists who contravene any of the provisions of the Act applicable to their

[188] Public Health Act, 2012 (Act 851), s 167.
[189] Children's Act, 1998 (Act 560), s 2.
[190] See Act 857, ss 21, 48, 73, 110 and 140.
[191] Ibid.
[192] Ibid (n 63).

professions commit a criminal offence.[193] It has already been suggested that the selective criminalization of professional conduct under the Act amounts to selective justice. Under the Mental Health Act, 2012 (Act 846), it is a criminal offence to wilfully subject a person with mental disorder to discrimination and other treatment that undermine the fundamental human rights of that person. This crime also attracts a fine with or without a prison term.[194]

In accordance with Act 29, a medical professional may be found guilty of *causing harm by omission* if that professional intentionally and unlawfully withholds a duty to give the medical or surgical treatment necessary to prevent harm to a patient.[195] A nurse, for instance, may face this criminal charge where that nurse fails to administer a prescribed medication to a patient, thereby causing harm to that patient. Also, performing a procedure on or detaining a patient without that patient's consent may amount to criminal assault contrary to Sections 84 of Act 29. Under the Act, *abortion* is also criminalised, except that which is conducted by a registered medical practitioner in a licensed facility.[196] In addition to these conditions, the pregnancy must have resulted from rape, defilement, or incest and the abortion must have been requested by the victim or a lawful guardian. Abortion is also permissible under the law if continuance of pregnancy poses fatal risk or some physical or mental injury to the pregnant person; or where there is substantial risk that the baby may suffer some serious physical abnormality or disease if born.[197] Under the same enactment, a pregnant person who attempts or procures unlawful abortion commits a crime, and anyone who aids her in that endeavour is equally guilty.[198]

In *Roe v. Wade*,[199] the United States Supreme Court adopted the view that the right of the pregnant person to cause abortion was enshrined in the Constitutional right to privacy and personal liberty. The court then considered issues of social stigma, physical and mental health, and the financial implications of unwanted pregnancy on a person and took the position that in the first trimester, abortion may not be regulated beyond requiring that it be performed by a registered medical practitioner under medically safe conditions. But in the second trimester, abortion may be prohibited if is in the interest

[193] See Act 857, ss 21, 73 and 140.
[194] See Act 846, s 94.
[195] See Act 29, ss 77-79.
[196] See Act 29, s 58.
[197] Ibid.
[198] See the case of *Obeng v. The Republic* [1971] 2 GLR 107-127 in which the Court of Appeal discusses criminal culpability for abortion.
[199] 410 US 113 (1973).

of maternal health. And, in the third trimester, when the foetus has reached viability, regulations may prohibit abortion to protect the potential human life of the unborn baby, except where it is necessary to protect the life of the pregnant person. The effect of the decision in *Roe v. Wade* was that a total prohibition of abortion was unlawful in American law and a person had some window of opportunity to terminate her own pregnancy for whatever reason. In the Ghanaian context, where poverty abounds, and where adoption and foster care systems have not been normalised,[200] there may not be sufficiently justifiable grounds to retain the current form of abortion law. In *Roe v. Wade*, the court did not find a constitutional basis for the moral argument that an unborn child was a person with protected rights. In fact, before parliament passed into law the Road Traffic (Amendment) Bill into law in 2020, the observation in *Roe v. Wade* was applicable to the Constitution and Act 29, where an unborn baby could not be the subject of murder or manslaughter. Section 66 of Act 29 made the word 'person' apply to a baby only after birth. However, the new Act which amended the Road Traffic Act, 2004 (Act 683) which was subsequently amended by the Road Traffic (Amendment) Act, 2008 (Act 761) makes a driver liable for the offence of manslaughter if he is involved in an accident that leads to the death of an unborn child,[201] thereby altering Ghana's abortion law.

Criminal Negligence

Act 29 provides for *criminal negligence*. Section 12 of the Act provides that 'a person causes an event negligently, where, without intending to cause the event, that person causes it by a voluntary act, done without the skill and care reasonably necessary under the circumstances.' For my purposes, the quoted Section has two relevant illustrations under it:

> (a) A., a woman having no knowledge of midwifery, acts as a midwife, and through her want of skill she causes death. Here, if A. knew that a properly qualified midwife or surgeon could be procured, the fact of A. so acting without possessing proper skill and without any necessity for so acting, is evidence of negligence, although it appears that she did her best. But if the emergency was sudden, and no properly qualified midwife or surgeon could be procured, A. is not guilty of negligence, provided she did the best she could under the circumstances.

[200] Part IV of the Children's (Amendment) Act, 2016 (Act 937) and the Adoption Rules, 2003 (CI. 42) provides the law and procedure for adoption and fosterage of children in Ghana. However, adoption and foster parenting currently does not appear to be a normal feature of Ghanaian family life.
[201] See Act 683, s 1 (as amended).

> (c) If the law directs poisons to be sold only in bottles of a particular kind, and the chemist sells poison in a common bottle, this is evidence of negligence, even though the common bottle be labelled "Poison".

According to Section 82 of Act 29, if for purposes of treating a person medically or surgically, a caregiver intentionally causes harm to that person such that, if reasonable skill and care was exercised under the circumstances, that caregiver should have known that that treatment was plainly improper, the harm should be deemed to have been caused negligently. Under Ghanaian law, civil and criminal negligence has been held to have the same meaning, the only difference being that there are degrees of criminal negligence, whereas no such degrees exist under civil negligence. In *The State v. Tsiba*[202] the court observed as follows:

> Negligence, whether it be a ground for a claim in a civil court for compensation or an essential ingredient in the constitution of a crime, is the omission to take care where there is a duty to take care, with this difference that whereas in a civil claim there are no degrees of negligence, such degrees exist in a criminal court.

There are two types of criminal negligence under Act 29. In the first type, the seriousness or degree of the negligent conduct does not amount to a reckless disregard for human life, whereas the second type is a more serious form of negligent conduct that amounts to a reckless disregard for human life.[203] If the less serious form of negligent conduct results in harm or danger to a person, a medical professional may be charged with the offence of *causing harm negligently* or *negligently endangering the life of a person* contrary to Sections 72 or 73 of the Act respectively. When a patient dies as a result of a criminally negligent conduct, the professional is not to be convicted of manslaughter unless the conduct in question amounted to a reckless disregard for human life.[204] But that professional may be charged with *causing harm negligently*.[205] The second type of criminal negligence, which fits the description of reckless disregard for human life, is therefore necessary to convict for manslaughter. The Ghanaian court has had substantial difficulty with defining 'reckless disregard for human life'[206] but what fits that description may be determined by the circumstances of each case. It is possible,

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[202] [1962] 2 GLR 109-114.
[203] See discussion in PK Twumasi, *Criminal Law in Ghana* (Ghana Publishing Corporation, Tema 1985) 87, 97.
[204] Criminal Offences Act, 1960 (Act 29), s 51.
[205] Ibid (n 201) p 602.
[206] Ibid (n 200).

however, that a patient's injury or death may be caused accidentally, in which case the courts have advocated that a caregiver should not be unjustly punished.[207] In *The State v. Kwaku Nkyi*[208] the Kumasi High Court found that the negligence of an accused student nurse in mistaking arsenic for the drug he intended to administer did not amount to a reckless disregard for human life. The student nurse was therefore acquitted of the charge of manslaughter by negligence. It is important to note that where another person had inflicted some injury on a person as result of which that person is now in the care of a medical professional, the chain of causation of death is not broken by the mere failure of medical care unless the treatment was grossly negligent or unless the death was not a foreseeable consequence of the treatment.[209]

Constructing the Ghanaian Context and the Way Forward

The illustrated background engenders the idea that medical misconduct and malpractice in Ghana occurs within a unique context of *regulatory, institutional, political, sociocultural,* and *legal determinants*. The regulatory aspect comprises the *policy advisory* and *administrative apparatus* for medical professions, in addition to the *development and enforcement of standards* for medical practice. Under Act 857, there are separate regulatory bodies established by law which are vested with these functions. These bodies operate under the authority of Parliament and the Minister of Health, and under the supervision of the courts. While commendable gains have been made in the regulation of these professions over the past decades, there are outstanding issues regarding the development of standards for practice. We have already argued that regulatory standards for medical practice may not be sufficient for the current regulatory regime. In our exploration of existing standards developed by the various regulatory bodies, we uncovered only those for nurses and doctors, which date back to the early 1970s. Given the fact that medical practice evolves, and new specialties have emerged within the various medical professions in the country in recent years,[210] the need exists for a more comprehensive, uniform codification of practice standards amenable to the law in its current state. This is also important, particularly on the basis that failure to comply with professional standards is criminalized under the current regulatory regime.

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[207] Dictum of Lord Denning in *Roe v. Minister of Health* [1954] 2 All ER 131.

[208] Ibid (n 135).

[209] Criminal Offences Act, 1960 (Act 29), s 64(d).

[210] Specialist training colleges have been established under the Specialist Health Training and Plant Medicine Research Act, 2011 (Act 833). These institutions are to equip professionals with advanced and differentiated skills.

The institutional aspect comprises existing *internal managerial strategies* formulated for purposes of directing the day-to-day clinical practice and the *training system* for medical professionals in the country. We have earlier suggested that the nature of conducts that fit the description of medical misconduct and malpractice point to important inadequacies in the institutional management and training systems. Accordingly, there may be the need for empirical enquiry into the existing training systems to explore the possibility of integrating into training curricula programmes that address medical malpractice and misconduct from the training stage. This may include an introduction to Bioethics and Medico-Legal Issues and the implementation of mental health programmes for all categories of medical professional trainees. Regarding management of healthcare institutions, the reports have shown that multi-institutional collaboration has been effective in battling issues of professional misconduct and malpractice in the country. There may therefore be need for further exploration of such collaboration in dealing with similar issues.

Politically, issues of *equipment and infrastructure, personnel, and incentives* affect medical practice in the country. Arguably, the rate of increase in patient medical knowledge and expectations is disproportional to the rate of improvement in healthcare equipment and infrastructure. Also, the political organisation of healthcare institutions has the ability to influence professional conduct. Anecdotal evidence suggests a seemingly calcified prevailing system where the internal political control of public healthcare institutions is practically reserved for a few professional groups and the opinion of those groups naturally run supreme over others. This observation underpins recent professional disputes in the country, where medical laboratory scientists have taken on medical practitioners over who should head medical laboratories in the country.[211] Not long ago, a variant of this political conflict was manifested in a brawl between the medical director of the Ankaful Psychiatric Hospital and nurses at the facility, which resulted in the removal of the doctor from office.[212] Even among the same professional groups, the extent to which conflicts influence professional conduct can be fatal, as suggested by the incident involving the HIV-contaminated drinking water at the Korle-Bu Teaching Hospital.[213] Historically, the medical doctor has occupied a position

[211]K Siaw, 'Ghana Medical Association Demands Return of Lab Physicians' <https://www.myjoyonline.com/ghana-medical-association-demands-return-of-lab-physicians/> accessed 15 October 2021.

[212]Myjoyonline.com, 'Wild Jubilations Over Removal of Ankaful director' <https://www.myjoyonline.com/wild-jubilations-over-removal-of-ankaful-director/> accessed 15 October 2021.

[213]Ibid (n 58).

of influence in the history of Ghana, especially in the years prior to independence. There have been times, for instance, where a District Medical Officer in the Gold Coast was also clothed with judicial authority as commissioner, having the jurisdiction to remand and grant bail in criminal actions and to exercise other authorities sanctioned by the Governor.[214] Additionally, by virtue of his professional role in the Ghanaian clinical setting, the doctor naturally exudes a domineering influence in the healthcare environment. This reality makes him a natural party to inter-professional conflicts. This notwithstanding, there is an unavoidable indication of inequitable access to political control in Ghana's public health institutions. To mitigate the potential implications for professional misconducts and malpractices, the need exists for a conscious institutional effort to install a balanced political regime. Incentives also influence professional motivation for the conducts that underlie the issues of medical malpractice and professional misconducts. While the global picture may suggest that healthcare financing and incentivisation of the Ghanaian medical professional is adequate,[215] the nature of professional misconducts and malpractices discussed and the rate of migration of health professionals to more favourable economies[216] paint a contrary picture. A stakeholder review of the current incentive regime is therefore imperative.

Pertaining to the sociocultural aspect, the disposition of the Ghanaian toward medical practice may be influenced by his *cultural inclinations*, *religion* and issues of *disability*. It has been observed that the sanctity of life is a value that is monumentally engrained in the social psyche of the Ghanaian.[217] Yet, in his pursuit of self-preservation through medical care, the Ghanaian patient's proclivity for reparations for personal harm suffered from medical malpractice has run counter to this observation. In the *Chinbuah*[218] case, the High Court observed that while anecdotal evidence abounds for preventable death, hardly do stakeholders become apprised of them. Clearly, there is a certain general reluctance to exercise formal options such as litigation and prosecution in confronting perceived medical wrongs. In the stillborn-babies scandal that struck the Komfo Anokye Teaching Hospital, mothers who had previously lost their babies under similar questionable circumstances made no formal disclosures until one such incident

[214]The Courts (Powers of Medical Officers) Order. No. 14 of 1937. See LEV M'Carthy, *The Laws of the Gold Coast (Including Togoland Under British Mandate)* (Rev edn Government Printers 1937).
[215]K Saleh, *The Health Sector in Ghana: A Comprehensive Assessment* (World Bank, Washington 2013).
[216]Ibid (n 89).
[217] Government of Ghana, *White paper on the Report of the Constitution Review Commission of Inquiry Presented to the President* (White Paper, 2012).
[218] Ibid (n 182).

become public knowledge.[219] It is possible that this reluctance to hold the medical professional to account is rooted in the faith and respect that the ordinary Ghanaian accords the medical man. If so, this may flow from the cultural disposition toward authority figures. Indeed, the courts have at some point taken judicial notice of this cultural fact and recognised that elders and authority figures such as chiefs and family heads occupy such honourable positions in the Ghanaian society that it would be dishonourable for their subjects to hold them to account through litigation in matters concerning their fiduciary duties.[220] Another dimension of culture to the non-formal pursuit of medical malpractice claims is the fact that the known approaches to dispute resolution in Ghanaian societies has not always been formal but customary.[221]

Historically, the Ghanaian has known the traditional methods of arbitration, negotiation and mediation, long before the advent of colonialism and its accompanying common law forms of dispute resolution.[222] Considering that these pre-existing methods remain less expensive, less adversarial, and relatively time efficient, they would naturally appeal to the ordinary Ghanaian. It is therefore likely that a family that has lost a member to medical malpractice may prefer to sit with the medical professional or management of the facility in question to come to some form of settlement, and this settlement might comprise the offer and acceptance of apologies, with a nominal sum as compensation for the loss caused. However, not all malpractice issues may be resolved through non-formal methods. Section 1 of the Alternative Dispute Resolution (ADR) Act, 2010 (Act 798) particularly proscribes the application of ADR methods to matters relating to public interest; the environment; enforcement and interpretation of the Constitution; and any other matter that by law cannot be settled by an ADR method.[223] SA Brobbey had opined that ADR methods did not apply to criminal matters under Ghanaian law.[224]

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[219] Ibid (n 56).

[220] See *Abude v. Onano* (1946) WACA 102.

[221] Korankye-Sakyi FK, The civil justice reform debate: An African perspective. In Yin, E. T., & Kofie, N. (Eds.), *Advancing Civil Justice Reform and Conflict Resolution in Africa and Asia: Comparative Analyses and Case Studies* (pp. 46-62), (New York: IGI Global, 2021); JA Davies and DN. Dagbanja, 'The Role and Future of Customary Tort Law in Ghana: A Cross-Cultural Perspective' (2009) 26 Ariz.J. Int'l & Comp. L. 303, 304.

[222] S A Brobbey, The Law of Chieftaincy in Ghana (Advanced Legal Publications 2008) 367. See also Korankye-Sakyi, ibid (n 221).

[223] The Act now provides a statutory framework for the use of traditional methods of dispute resolution (mediation, negotiation, and customary arbitration) and sets up an ADR centre to facilitate matters related to ADR.

[224] Ibid (n 220) 412.

Granted that this position is correct, non-formal or ADR methods would not suffice to address a medical malpractice matter which is also the subject of a crime. Also, agreement between parties is necessary for adoption of ADR and for arriving at settlements acceptable to both parties, but this may be difficult to achieve in some situations.

Notwithstanding these limitations, both native and foreign authors alike have observed the continuous importance of ADR systems, even to advanced societies, and have advocated for its normalisation in formal dispute resolution systems.[225] Kass, for instance, has strongly recommended the normalisation of ADR methods such as arbitration and mediation in the resolution of medical malpractice claims in America, on the basis that they are less adversarial and less costly as opposed to formal litigation.[226] To mitigate the setbacks pertaining to non-agreement in ADRs, and to circumvent the complexities associated with pursuing and proving medical malpractice claims, Owusu-Dapaa proposes that it may suffice to adopt a 'no-fault compensation scheme' whereby persons who suffer medical injuries who meet certain criteria would be entitled to some form of compensation without necessarily assuming the burden of proving any fault of the medical professional.[227] We agree that this proposition is a potentially favourable alternative and a fair complement to the existing avenues for addressing medical malpractice claims in Ghana. A noteworthy observation, however, is that ADR is extended to criminal matters involving minors under Section 32 of the Children's Act 1998 (Act 560). Under the said section, a Child Panel may mediate a criminal matter and seek to facilitate reconciliation between a child and a person offended by that child. The Panel is permitted under the law to propose apology and restitution to the offended person. We argue that extension of a similar regime to criminal malpractice matters may encourage honesty and openness by the professional about medical errors and injuries. With such a less adversarial procedure, offending medical professionals or institutions may be more inclined to accept responsibility for their conducts in a more restitutive atmosphere.

It is common knowledge that the Ghanaian is incurably religious. The tenets of imported religion which are founded on forgiveness and the deference of retribution to spiritual

[225] Ibid (n 219-220).

[226] JS Kass, 'Medical Malpractice Reform—Historical Approaches, Alternative Models, and Communication and Resolution Programs' (2016) 18 AMA Journal of Ethics 299, 310.

[227] E Owusu-Dapaa, 'Medical Malpractices and the Complexity of Healthcare Litigation: Is There a Case for No-Fault Compensation Regime in England and Wales?' (2014) SSRN <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2462511> accessed 15 October 2021.

beings may account for the reluctance of the Ghanaian to formally pursue medical malpractice claims. The impact of religion in healthcare policy and delivery cannot be discounted in any serious inquiry into the Ghanaian healthcare system. A case in point is the colossal use of religion as justification for the criminalisation of LGBTTQQIAAP+ in the Promotion of Proper Human Sexual Rights and Ghanaian Family Values Bill, 2021. The Bill, which is currently before the Ghanaian Parliament will, if passed into law, also treat homosexual and related tendencies as medical conditions. Even at the global level, an association between religion and the determination and direction of global healthcare policy has been observed.[228] This background also supports the idea that the religious inclinations of the medical professional have potential implications for his clinical conduct, some of which may be significantly associated with medical malpractices. Disability may also determine the nature and outcome of the professional-patient relationship and influence the patient's disposition toward medical conduct. In the case of *CFC Construction Ltd v. Attitsogbe*,[229] the Supreme Court of Ghana considered disability as a factor capable of dominating or overriding a person's free will. The variants of disability considered in that case included 'poverty or need of any kind, sickness, age, sex, infirmity of body or mind, drunkenness, illiteracy or lack of education, lack of assistance or explanation where assistance or explanation is necessary'. These disabilities potentially determine the power relations between the healthcare provider and the patient, and may as well nourish the paternalistic proclivities of the caregiver. For instance, a patient who is poverty-stricken, unaware of his health rights, and has no access to a lawyer may never pursue a malpractice claim. To ensure the administration of justice and to promote the development of healthcare law in Ghana, it is imperative that wrongfully injured patients are assisted with the tools to enable them prosecute their claims. Considering the gravity of disabling factors such as poverty and illiteracy in the country, this will require the normalisation of legal aid. Despite that Article 294 of the Constitution and the Legal Aid Scheme Act, 1997 (Act 542) provide a statutory framework for legal aid in Ghana, access to legal aid seems non-existent, possibly as a result of funding challenges. There may therefore be the need for an aggressive stakeholder consultation on disability and legal aid financing with the aim of controlling the vicious cycle.

[228] F Winiger and S Peng-Keller, 'Religion and the World Health Organization: An Evolving Relationship' (2021) 6 BMJ Global Health <https://gh.bmj.com/content/bmjgh/6/4/e004073.full.pdf> accessed 10 October 2021.

[229] Civil Appeal NO. J4/21/2004. Unreported judgement of the Supreme Court dated 8 March 2006.

Legally, much has been done through legislation and professional regulation, and the judiciary has complemented these efforts through the few medicolegal issues that have terminated in the courts. But the evolution of medical practice and of the social condition of the Ghanaian have altered the landscape of professional practice, thereby necessitating a conscious review of the existing legal regime. Under the Specialist Health Training and Plant Medicine Research Act, 2011 (Act 833), colleges of nurses and midwives; physicians and surgeons, and pharmacists have now been established and are churning out variants of medical specialists with advanced clinical expectations. However, existing regulatory standards that guide medical practice are yet to be reviewed to embrace the associated impact on practice. Additionally, Ghana has yet to take statutory positions on modern healthcare issues such as organ harvesting and transplantation; advance directives and living wills; body modification and gender alteration; and surrogacy.

Recent advocacy for gay rights in Ghana is one indication that the once conservative Ghanaian society is now amenable to liberalist social behaviours, many of which have implications for healthcare policy and law. Recently, amid controversial public debate, the MDC closed down a facility that has successfully pitched into the healthcare market with body sculpting surgeries. This followed a report that the body of a woman, who had died while undergoing a related procedure at the same facility, had been disposed of clandestinely without reference to her family.[230] Considering the challenging context within which medicine is practiced in the country, it would be non-progressive to neglect these modern issues to the uncertainties of medical ethics. Owusu-Dapaa has opined that Ghana may draw lessons from jurisdictions like England and Wales when considering reforms to the regulatory regime for healthcare delivery.[231] But if we must consider a foreign ideal, we must not lose sight of the contextual attributes of the Ghanaian healthcare system. We must be drawn to adaptations and modifications that better serve the Ghanaian interest. By this suggestion, we adopt the view of the sociological school of jurisprudence that laws must reflect the living or social conditions of the people and must balance competing interests.[232] If the objects of law must satisfactorily serve

[230] BBC News Pigin, 'Ghana Court Charge Fake Body Sculpting Doctor Over Mystery Death of Patient' <https://www.bbc.com/pidgin/tori-44306397> accessed 20 October 2021.

[231] E Owusu-Dapaa, 'An Inquiry into the Emergence of Health Care Law in England and Wales as a Distinct Body of Law - What Lessons Can be Drawn From this in Relation to Ghana?' (D Phil thesis, Lancaster University 2016) <https://eprints.lancs.ac.uk/id/eprint/79754/1/2016_Ernest_Owusu_Dapaa_PhD_.pdf> accessed 2 August 2021.

[232] JA Gardner, 'The Sociological Jurisprudence of Roscoe Pound (Part I)' (1961) 7 Vill. L. Rev. 1.

the subjects of law, then reference to context must be indispensable. In the absence of enabling statutory interventions, the courts have a constitutional duty to ensure that individual and patient rights are protected. Judicial activism may be advanced through a political process approach and aim at protecting minority rights.[233] Kass's view that medical malpractice reforms have been the product of political processes seems attractive here.[234] But while judge-made laws are necessary to maintain the realm, the judiciary must also bear cognisance of the constrained context of medical practice when applying themselves to the relevant issues before them. The context must also have a bearing on the gravity of damages awarded and the sentences imposed. We would suggest a precaution in the voice of Lord Denning, that 'we must not look at the 1947 accident with 1954 spectacles,' and that 'it is so easy to be wise after the event and to condemn as negligence that which was only a misadventure.'[235]

Conclusion

Whether one takes a system or person-centred view of medical practice in Ghana, what determines the outcome of the professional-patient relationship are potentially issues of regulatory, institutional, political, sociocultural, or legal nature. These issues may be plotted out to construct the unique context within which healthcare delivery is situated and in which medical misconducts and malpractices occur. While the existing statutory and regulatory regime have sustained healthcare administration, clinical practice, and the resolution of medicolegal issues in the country, they may be inadequate to address emerging healthcare issues such as surrogacy, body modification, organ harvesting and transplantation in the light of potential malpractices and ethical challenges. Additionally, a general reluctance of Ghanaian patients to resort to formal processes in pursuing malpractice claims is observed, as a likely result of disabling factors perceived by aggrieved patients. This necessitates exploration, recognition and normalisation of alternatives such as ADR and no-fault compensation schemes. It is however imperative, in the interest of justice and fairness, that medical malpractices and misconducts are scrutinised and sanctioned with due regard to the prevailing contextual constraints.

[233] See discussion of political process theory in MJ Klarman, 'The Puzzling Resistance to Political Process Theory' (1991) 77 Virginia Law Review 747, 824.
[234] Ibid (n 224).
[235] Ibid (n 205).

References

Abbey EE, 'Korle Bu Doctor Poisons Colleague's Water with HIV Blood' <https://www.graphic.com.gh/news/general-news/korle-bu-doctor-poisons-colleague-s-water-with-hiv-blood.html> accessed 8 September, 2021.

Achiaw NO and Mensah M, 'Beckley's Alleged Victim Speaks 'I am Around' And Is Willing to Appear in Court' *Daily Graphic* (Accra 8 May 2002) 1.

Adu-Gyamfi A and Brenya E, 'Nursing in Ghana: A search for Florence Nightingale in an African City' (2016) <https://www.hindawi.com/journals/isrn/2016/9754845/>accessed 18 September 2021.

Akiwumi A, *Higher Education for Nurses (Inter-Faculty Lecture, University of Ghana, Legon, Ghana*, *1970)* (Ghana Universities Press 1971).

Antwi J and Phillips D, Wages and Health Worker Retention in Ghana: Evidence from Public Sector Wage Reforms (2012) <https://openknowledge.worldbank.org/bitstream/handle/10986/13581/691070WP00 PUBLOGhanaMigrationSalary.pdf?sequence=1> accessed 10 September, 2021.

Apedzi AK, An Assessment of Health Worker's View on the Current Single Spine Pay Policy. A Case Study on Doctors and Nurses in Greater Accra Region, Ghana' (2019) 20 BJSTR 15471,15479 <https://biomedres.us/pdfs/BJSTR.MS.ID.003527.pdf> accessed 10 September 2021.

Bal S 'An Introduction to Medical Malpractice in the United States' (2009) 467 Clin Orthop Relat Res 339, 347.

Bannerman ER, 'Negligence—The Reasonable Man and the Application of the Objective Test in Anglo-American Jurisprudence [1969] 2 UGLJ 69, 88.

BBC News Pigin, 'Ghana Court Charge Fake Body Sculpting Doctor Over Mystery Death of Patient' <https://www.bbc.com/pidgin/tori-44306397> accessed 20 October 2021.

BBC News, 'Ghana 'Baby-Harvesting Syndicate' Arrested' <https://www.bbc.com/news/world-africa-55751290> accessed 7 September 2021.

BBC News, 'Ghana Hospital Given 14 Days to Find 'Missing Babies' <https://www.bbc.com/news/world-africa-26382532> accessed 7 September 2021.

Blake V, 'Health Law: When is a Patient-Physician Relationship Established' (2012) 14 American Medical Association Journal of Ethics 403,406 <https://journalofethics.ama-assn.org/article/when-patient-physician-relationship-established/2012-05> accessed 15 September 2021.

Bokpe SJ 'Ali-Gabass Begins 25-year Jail Term (Photos)' <https://www.graphic.com.gh/news/general-news/ali-gabass-behins-25-year-jail-term-photos.html> accessed 7 September 2021.

Brobbey SA, The Law of Chieftaincy in Ghana (Advanced Legal Publications 2008) 367.

Cullati S and others, 'When Team Conflicts Threaten Quality of Care: A Study of Health Care Professionals' Experiences and Perceptions' (2019) 3 Mayo Clin Proc Innov Qual Outcomes 43,51 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6408685/> accessed 8 September 2021.

Dapaah JM, 'Attitudes and Behaviours of Health Workers and the Use of HIV/AIDS Health Care Services' (2016) Nurs Res Pract <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5225383/pdf/NRP2016-5172497.pdf> accessed 8 September 2021.

Davies JA and Dagbanja DN, 'The Role and Future of Customary Tort Law in Ghana: A Cross-Cultural Perspective' (2009) 26 Ariz.J. Int'l & Comp. L. 303, 304.

Dworkin RM, 'The Model of Rules,' (1967) 35 U Chi L Rev <https://chicagounbound.uchicago.edu/uclrev/vol35/iss1/3> accessed 23 September, 2021.

Edwin AK, Non-Disclosure of Medical Errors an Egregious Violation of Ethical Principles' (2009) 43 Ghana Medical Journal 34, 39.

Gardner JA, 'The Sociological Jurisprudence of Roscoe Pound (Part I)' (1961) 7 Vill. L. Rev. 1.

Garner BA (ed), Black's Law Dictionary (10th edn Thomson Reuters, St. Paul 2014).

Ghana Health Service, *Ghana Health Service Code of Conduct and Disciplinary Procedures* (GHS, Accra 2018)

<https://www.ghanahealthservice.org/downloads/GHS_Code_of_Conduct_and_Disci plinary_Procedures_2018.pdf> accessed 20 September 2020.

Ghanaweb.com, 'Ritual Killings for Human Parts, Others - These Cases Have Shaken Ghana Since The 1980s' <https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Ritual-killings-for- human-parts-others-These-cases-have-shaken-Ghana-since-the-1980s-1343947> accessed 6 September 2021.

Goiran HN and Storer E, 'A Tale of Two Doctors: A Comparison of The Dekker and Nitschke'<https://static1.squarespace.com/static/5c7f6297b10f25f3e868e2d2/t/5c80d0059140b 7124b93c3a1/1551945735326/2002-2014-Dekker-and-Nitschke1.pdf> accessed 3 September 2021.

Government of Ghana, *White paper on the Report of the Constitution Review Commission of Inquiry Presented to the President* (White Paper, 2012).

Jackson E, Medical Law: Text, Cases and Materials (4th edn OUP 2016) 2.

Kass JS, 'Medical Malpractice Reform—Historical Approaches, Alternative Models, and Communication and Resolution Programs' (2016) 18 AMA Journal of Ethics 299, 310.

Klarman MJ, 'The Puzzling Resistance to Political Process Theory' (1991) 77 Virginia Law Review 747, 824.

Korankye-Sakyi FK, The civil justice reform debate: An African perspective. In Yin, E. T., & Kofie, N. (Eds.), *Advancing Civil Justice Reform and Conflict Resolution in Africa and Asia: Comparative Analyses and Case Studies* (pp. 46-62), (New York: IGI Global, 2021).

M'Carthy LEV, *The Laws of the Gold Coast (Including Togoland Under British Mandate)* (Rev edn Government Printers 1937).

Mehta SS and Edwards ML, 'Suffering in Silence: Mental Health Stigma and Physicians' Licensing Fears' (2018) 3 American Journal of Psychiatry 11 <https://psychiatryonline.org/doi/10.1176/appi.ajp-rj.2018.131101> accessed 9 September 2021.

Ministry of Health, *Ghana National Healthcare Quality Strategy (2017-2021)* (Ministry of Health, Accra 2016) <https://www.moh.gov.gh/wp-content/uploads/2017/06/National20Quality20Strategy20Ghana.pdf> accessed 10 September, 2021.

Myjoyonline.com 'Gay Doctor Confesses Sodomising 16-Year-Old SHS Student' <https://www.myjoyonline.com/gay-doctor-confesses-sodomising-16-year-old-shs-student/> accessed 7 September 2021.

Myjoyonline.com, 'Wild Jubilations Over Removal of Ankaful director' <https://www.myjoyonline.com/wild-jubilations-over-removal-of-ankaful-director/> accessed 15 October 2021.

Myjoyonline.com, '11 Persons Arrested for Engaging in Baby Harvesting, Human Trafficking – EOCO and MDC Reveals' <https://www.myjoyonline.com/11-persons-arrested-for-engaging-in-baby-harvesting-human-trafficking-eoco-and-mdc-reveals/> accessed 7 September 2021;

Noretti AM, 'Tribunal Adjourns Beckley's Case' *Daily Graphic* (Accra 9 July, 2002) 40.

Norman ID and others, 'The Constitutional Mandate for Judge-Made-Law and Judicial Activism: A Case Study of the Matter of Elizabeth Vaah v. Lister Hospital and Fertility Centre' (2012) 6 The Open Ethics J 1, 7.

Opare M and Mill JE, The Evolution of Nursing Education in a Post-Independence Context—Ghana from 1957 to 1970' (2000) 22 Western Journal of Nursing Research 936, 944.

Owusu-Dapaa E, 'An Inquiry into the Emergence of Health Care Law in England and Wales as a Distinct Body of Law - What Lessons Can be Drawn From this in Relation to Ghana?' (D Phil thesis, Lancaster University 2016) <https://eprints.lancs.ac.uk/id/eprint/79754/1/2016_Ernest_Owusu_Dapaa_PhD_.pd> accessed 2 August 2021.

Owusu-Dapaa E, 'Empowering Patients in Ghana: Is There a Case for a Human Rights-Based Health Care Law? (2015) 1 Lancaster University Ghana Law Journal 91, 114.

Owusu-Dapaa E, 'Medical Malpractices and the Complexity of Healthcare Litigation: Is There a Case for No-Fault Compensation Regime in England and Wales?' (2014) SSRN <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2462511> accessed 15 October 2021.

Pandit MS and Pandit S, 'Medical negligence: Coverage of the Profession, Duties, Ethics, Case law, and Enlightened Defense - A Legal Perspective' (2009) 25 Indian J Urology 372, 378.

Perry AL, 'Malpractice in Dental Anaesthesiology' (1964) 13 Clev.-Marshall L. Rev. 319.

Plange-Rhule G, 'Medical Negligence in Ghana – Another Look at Asantekramo' (2013) 2 Postgraduate Medical Journal of Ghana 41, 43.

Quaicoe-Duho R, 'MoH Gives Ultimatum to KATH to Produce Five Stillborn Babies' <https://www.graphic.com.gh/news/general-news/moh-gives-ultimatum-to-kath-to-produce-five-stillborn-babies.html> accessed 7 September 2021

Saleh K, *The Health Sector in Ghana: A Comprehensive Assessment* (World Bank, Washington 2013).

Semevor P, 'Engaging Dr Ali Gabass Will Be an Attack on UCC's Reputation – Bono Regional Director of Children Department' <https://www.myjoyonline.com/engaging-dr-ali-gabass-will-be-an-attack-on-uccs- reputation-bono-regional-director-of-children-department/> accessed 7 September, 2021.

Siaw K, 'Ghana Medical Association Demands Return of Lab Physicians' <https://www.myjoyonline.com/ghana-medical-association-demands-return-of-lab-physicians/> accessed 15 October 2021.

Twumasi PK, *Criminal Law in Ghana* (Ghana Publishing Corporation 1985) 87, 97.

Winiger F and Peng-Keller S, 'Religion and the World Health Organization: An Evolving Relationship' (2021) 6 BMJ Global Health <https://gh.bmj.com/content/bmjgh/6/4/e004073.full.pdf> accessed 10 October 2021.

World Health Organization, 'The 2021 update, Global Health Workforce Statistics' (2021) <https://www.who.int/data/gho/data/themes/topics/health-workforce> accessed 25 October 2021.

World Health Organization, *The World Health Report: 2006: Working Together for Health*. (World Health Organization 2006). <https://apps.who.int/iris/handle/10665/43432> accessed 25 October 2021.

Yin ET and Beamie MS, Costs and delays in accessing justice: A comparative analysis of Ghana and Sierra Leone. In Advancing Civil Justice Reform and Conflict Resolution in Africa and Asia: Comparative Analyses and Case Studies, (New York: IGI Global, 2021).

Yin ET and Black JM, The legal anthropology of marriage in Ghana: Presenting power dynamics through legal arenas (2014) *International Journal of Current Research, 6* (12), 10696-10704.

Yin ET, Atupare PA, Kofie N, Owusu LP and Botchway TP, Rights and religious belief in maintaining prison social order (2021) *UCC Faculty of Law Journal, 1*(1).

Yin ET, Religion, rehabilitation and reintegration of inmates into mainstream society. In A. Balloni, & R. Sette (Eds.), *Handbook of Research on Trends and Issues in Crime Prevention, Rehabilitation, and Victim Support* (pp. 398–414), (New York: IGI Global, 2020).

Yin, ET Religion as an Organising Principle in Ankaful Maximum Security Prison, Ghana (Published Doctoral Thesis, University of Cape Coast, 2018).