

Legal and Ethical Issues in the Demand for Payment before Treatment in Nigerian Hospitals

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Abstract

In recent time, accessibility of hospital or health care services especially in emergency cases has been an issue of great concern not only in Nigeria but also in the entire global village. The major hindrance to this accessibility is the insistence of medical practitioners and institutions on advance payment of fees before treatment. As a result of this stringent condition, lives have been lost and patients' conditions deteriorated beyond management resulting in avoidable permanent injuries. This leads to the expression of disgust by members of the public. This article discusses the legal and ethical issues arising from the demand for payment of fees before treatment in hospitals. In doing so, certain pertinent questions are attempted: Is there any legal basis for demanding advance payment before treatment? Are medical practitioners within their morals in withholding treatment until their fees are paid? The article makes a comparative analysis of the practice in Nigeria and that in other jurisdictions. What is found is that even though the Nigerian situation is not too different from what obtains in other environments, the Nigerian position is not backed by any legislation and as such, if a medical practitioner fails to treat a patient in an emergency situation, nothing can be enforced against that medical practitioner. The paper concludes that the situation in Nigeria needs to change in order to be in consonance with best practices in the ever globalizing village the world has become.

Keywords: Legal and Ethical Issues, Payment, Treatment, Nigerian Hospitals.

1. Introduction

In the history of medical practice, the basic legal and ethical question in the context of this paper is the affirmative duty, if any, to provide medical treatment. The historical rule is that a medical practitioner has no duty to accept a patient regardless of the severity of the illness. In this context, a medical practitioner's relationship with a patient was understood to be a voluntary and contracted one. However, once the relationship was established, the physician was under a legal obligation to provide medical treatment. This is in sharp contrast with the historical rule for hospitals which stipulates that they must act reasonably in their decisions to treat patients especially in emergency cases (Health Care Law 2006).

In view of the foregoing, and in view of the Hippocratic Oath which every medical practitioner is required to take, the question then arises whether a patient must get the attention of the medical practitioner in all circumstances regardless of the patient's ability to pay for his treatment? In other words, is there any law under which the medical practitioner may be compelled to treat a patient whether or not he pays? And assuming for the purpose of this paper, that there is no such law, is it ethical or morally right for a medical practitioner who is sworn to save lives, to turn down a patient in need of urgent medical attention simply because that patient is unable to pay at that moment? Various arguments have been canvassed on both sides as to the propriety of the demand for payment before treatment. Unlike in Nigeria where there is no clear legal reference point to compel a medical practitioner to treat a patient even when he is unable to pay at that time, some legal framework have been put in place in jurisdictions like America and the Philippines that require a medical practitioner to accept an indigent patient for treatment. This is basically predicated on the principle of preserving life at whatever costs possible. This issue is viewed with every seriousness in those jurisdictions that defaulters are penalized not just with payment of fines but also with imprisonment of various terms. The propriety or otherwise of the practice of demanding cash payment before treatment in Nigerian hospitals is the subject of this paper.

2. The Demand

The demand for cash deposits in Nigerian hospitals before a patient is treated has become a dangerous trend in the healthcare delivery service across the country. (Anaba et al 2009). Nigerians have helplessly lived with this trend which has occasioned loss of lives due to patients' inability to pay on demand, their hospitals bills. The demand for payment of fees by hospitals is predicate on the huge cost of health goods and services. Particularly for private hospitals, rents and salaries of staff, electricity bills, water bills as well as equipment and materials all have to be paid for by the hospitals. The argument is that if funds are not recovered through patient charges, such hospitals will close down within a short period of time.

Hospitals and medical practitioners have explained that it is a basic business arrangement - you need to make returns in terms of funds in order to sustain service. Someone has to pay for the services rendered by hospitals in order for them to survive. It is further argued that medical practitioners, like other professionals, are in service

for business and just like other professionals do not do their work gratuitously, it will be futile fulmination against medical practitioners to expect them not to charge their patients for rendering services to them. As (Anaba et al 2009) put it,

The doctor in my view is no more guilty than the seller of yam who refused to offer her tubers of yam free to a woman dying of starvation – and there are many such people in this country. What of the lawyer who asks a miserable tenant to provide fees ten times the rent in dispute?

Another reason proffered by medical practitioners for the demand for payment of deposit before treatment, is the very dishonest disposition of most Nigerians to issues of money. Many Nigerians, either for lack of it, or for deliberate and intentional decision not to pay, do not keep their obligation to pay after services have been rendered. At the very point of need, they promise to pay but once treatment is given and they get better, they refuse to pay, leaving the hospital in a dilemma. (Anaba et al 2009).

For the above reasons, but especially for the reason that medical treatment cost a lot of money, hospitals are very reluctant to treat patients who are unable to pay. Whether or not this practice is justified, is left for the realities of our time.

2.1 **Emergency Cases**

Notwithstanding the practice of demanding payment before treatment in normal cases, there is some reprise in emergency cases. This is so because in the case of the patient who is close to death or if it is an emergency case, the hospital can waive the requirement for payment temporarily for the purpose of saving life. The hospital can then subsequently recover the cost after treatment has commenced. This is necessary in order to sustain services, pay bills and stay in business. (Anaba et al 2009). This has nothing to do with ethics but has everything to do with the basic business principle of keeping afloat of whatever one is doing. In a normal situation, the patient pays for deposit at least. It is really in emergency cases that medical practitioners live out the tenets of the Hippocratic Oath and show great signs of the milk of human kindness. Fees are waived temporarily and the only focus is to save life.

2.2 **Treatment of Gunshot Victims**

One aspect of the subject that is akin to emergency cases, which in itself in most cases, is an emergency situation, is the treatment of gunshot victims. Ironically, gunshot victims, no matter how precarious, are denied treatment not on account of payment of fees, but on account of a prior clearance from the police. This unwritten law concerning the treatment of gunshot victims in Nigerian hospitals is predicated on the presumed duty of the police to prevent and detect crime as well as to apprehend offenders. (Obidimma and Obidimma 2013) The Police outlaw the treatment of gunshot victims without police clearance and this is based on the wrong assumption that majority of gunshot victims are armed robbers who would have been allegedly shot during the usual police – robbers' shootout (Omoyefa 2010). But the requirement of police clearance is definitely not a specific part of the law (Police Act, 2004) which prescribes the duties of the Police as follows:

The Police shall be employed for the prevention and detection of crime, the apprehension of offenders, the preservation of law and order, the protection of life and property and the due enforcement of all laws and regulations with which they are directly charged, and shall perform such military duties within and without Nigeria as may be required of them by or under the authority of this or any other Act.

As can be deduced from the above, the requirement of police clearance before treatment of gunshot victims is not a part of this law. But assuming that it is, and given that most of the gunshot victims are brought to hospitals as emergencies and given further that it is not usually pretty easy to obtain this police clearance in good time, is it appropriate to insist on the clearance at the expense of precious lives? Is there any indubitable proof at the point of the demand that a particular victim is an armed robber? Again, assuming he is an established armed robber, is there any justification to let him lose his life without any trial and conviction by the courts? The above questions must be answered in the negative and that makes the practice unacceptable. This must be the case because the practice does not accord any respect to the sanctity of life.

3. **Legal Issues in the Demand for Payment before Treatment.**

From the Nigerian point of view, there is nothing in the law that lays down any rule with regard to demand for payments from patients before treatment. Indeed, it is not a matter amenable to legislation because it would be so unfair and unreasonable to compel a hospital or a medical practitioner to accept and treat a patient who is incapable of paying for the services rendered to him. While it could certainly be wrong from the moral and

ethical point of view for a hospital to demand for cash payment before treatment, there is nothing wrong in law about that and a medical practitioner would have the legal competence to refuse to treat a patient who cannot afford his fees (Anaba et al 2009).

From the foregoing, it will be correct to say that no legal issues arise in a medical practitioner or a hospital refusing to treat a patient for inability to pay fees. That is to say, that the hospital does not incur any legal liability from doing so. This is so because in Nigeria, as in some other African countries, except in emergencies or for unconstitutional reasons, medical practitioners may legally accept or refuse patients as they wish but once accepted, the doctor enters into a contractual relationship – which is legally binding, with the patient (McQuoid-Mason, 2008). According to Carstens and Pearmain 2007, in such contractual relationships, the terms of the contract are usually implied except perhaps issues of payment of fees which is usually spelt out in advance.

The inference to be drawn from the foregoing is that a doctor is not bound to accept a patient who is incapable of paying his fees. The right of a patient to treatment which comes into play on the establishment of the doctor-patient relationship cannot be relied upon to found liability as that relationship only comes into existence only after the doctor has accepted the patient. As stated earlier therefore, a doctor's refusal to treat a patient for reason of inability to pay may be morally reprehensible but it does not make the doctor legally liable for any wrong.

4. Ethical Issues.

The pertinent question which arises for discussion under this section is whether it is ethically right for doctors to demand payment of fees before treatment? The answer to this question depends largely on the proper interpretation of the ethical rules of the medical profession, the nature or circumstances of the doctor-patient relationship, the urgency of the patient's need for treatment, and whether refusal to treat before payment would amount to professional misconduct on grounds of abandonment of the patient (McQuoid-Mason, 2011). To a large extent however, the resolution of this question depends on whether there exists a doctor-patient relationship based on the doctor accepting to treat the patient. This is what establishes a doctor-patient contract. This is so because once the doctor accepted to treat the patient, he enters into a contractual relationship with the patient from which he cannot extricate himself unilaterally. (McQuoid-Mason 2011).

This contractual relationship creates some obligations especially on the part of the doctor. This obligation especially on the part of the doctor. This obligation is referred to as "the affirmative duty" in some parlance and it requires the doctor to provide medical treatment. As has been stated earlier, the historical rule is that a medical practitioner has no duty to accept a patient regardless of the severity of his illness. But once the relationship was established, the doctor was under a legal obligation to provide medical treatment and was a fiduciary in this respect. (Health Care Law 2006).

According to McQuoid-Mason 2011, terms that doctors agree to in a doctor-patient relationship include to:

- i. diagnose and treat complaints,
- ii. treat complaints in the normal manner,
- iii. obtain informed consent before treatment,
- iv. respect patients' confidentiality,
- v. treat patients personally unless referral to a third party is necessary,
- vi. treat patients with reasonable skill, competence and care, and
- vii. do not abandon patients until they are cured or other arrangements for treatment have been made.

This creates both an ethical and a legal duty to provide medical treatment. Therefore, once there is a doctor-patient relationship, all the ethical principles regarding the relationship come into play. As a result, a doctor may not abandon a patient on the grounds that he is unable to pay in advance for treatment without making alternative arrangements for the patient (McQuoid-Mason and Dada 2011). Thus, when a treatment relationship exists, the doctor must provide all necessary treatment to the patient whether or not the patient can pay unless the relationship is ended by the patient or by the doctor provided he gives the patient notice to seek another source of medical care. (Monge 1994). To do otherwise will amount to abandoning the patient. According to Boumil and Elias 1995, a patient is abandoned "when a physician interrupts a course of necessary treatment without proper notice and referral to a subsequent practitioner." Consequently, if a doctor undertakes treatment for a patient, such treatment may not be abandoned if it would harm the patient unless the patient makes it impossible for the doctor to treat him or her otherwise the doctor will incur liability. Under Nigerian law, this may amount to "infamous conduct in a professional respect". (Ogwuche 2006). In the Nigerian case of *Akintade v. C.M.D.P.D.T.* 2005, the Court of Appeal expressed the view that the myriad of circumstances that may constitute infamous conduct cannot be exhaustively set out in a code but would include such matters as neglect or disregard of a doctor's personal responsibilities to patients for their care and treatment.

4.1 **Justification of Request for Payment before Treatment.**

As has been discussed in this paper, demand for payment before treatment is not considered ethically justified for refusing to treat a patient who cannot afford to pay in the following situations:

- i. In a medical emergency,
- ii. When refusal to treat the patient will constitute abandonment of the patient, or
- iii. When a patient who has a good record of payments in advance is temporarily in lack of funds and requires ongoing treatment.

These situations do not satisfy the bioethical principles because patients in those circumstances cannot exercise autonomy as they have no choice because of their financial position and they also do not satisfy the principles of beneficence as the patients do not get any fair deal in these situations (McQuoid Mason 2011).

4.2 **Basis for Medical Ethics**

The relationship between a doctor and his patient is not always equally balanced. This is just because as the lawyer knows more about law than does his client, the doctor knows more about medicine than does his patient. As a result, the patient's attitude is poised between trust and general distrust, and such ambivalence leads naturally to a sense of inferiority. And there is need for a solution in this regard. The main function of medical ethics is to ensure that the potential superiority of the doctor is not abused (Mason and Smith 1987)

For the above reason, various ethical rules of the medical profession have been formulated to guide not only the practice but also the relationship between doctors and patients. These ethical rules can be found in a number of Conventions and Declarations. The foremost of all these is the Hippocratic Oath which covers several important ethical issues between doctors and patients. The Oath is an ancient pledge of medical ethical conduct. It addresses two important tenets: benefitting the ill and protecting patients against personal and social harm and injustice (The Hippocratic Oath 1825). The Oath represents the roots which sustain the intraprofessional code of conduct which in practice, represents the patient's main safeguard of what is generally considered to be his right (Mason and Smith 1987).

Additionally, the Declaration of Geneva (1948) as amended in Sydney (1968) represents the modern counterpart of the Hippocratic Oath and requires graduating doctors to declare: "The health of my patients shall be my first consideration" (World Medical Association 1948). Furthermore, the World Medical Association (WMA) International Code of Ethics (1949) states that: A Doctor must practice his (her) profession uninfluenced by motives of profit" (WMA International Code of Medical Ethics 1949). As can be deciphered from the foregoing, the WMA declarations indicate that doctors should put their patients' health interests before questions of payment. They require doctors to act in the best interests of their patients and maintain the highest standards of personal conduct and integrity. This is the basis for medical ethics: that patients should be assured at all times of the doctors' highest standard of personal conduct and integrity including the patients' interests which makes the request for payment secondary.

5. **The Practice in other Jurisdictions**

A comparative analysis of the doctor-patient relationship with regard to demand for payment before treatment shows that in almost all normal situations, the position is the same in Nigeria as in the United States of America, United Kingdom, South Africa as well as other countries including the Philippines. The position is that except in emergency cases, doctors and hospitals are in their rights to demand payment before treatment of patients. The difference between the situation in Nigeria and that in almost all other countries is that while there are legislations imposing restrictions on doctors and hospitals from demanding cash payments before treatment in emergency cases, there is no such legislation in Nigeria. Therefore, when doctors and hospitals in Nigeria accept to treat patients in emergency situations without demanding payment, they are acting on impulse and on the professional ethics of putting the interest of their patients uppermost. But we can do better than that by putting in place legislations to impose the restriction otherwise other nations would leave Nigeria behind in a world that has become a global village.

In Kenya, an African country, by May 2012, realizing that discrimination against poor and uninsured patients is a common occurrence in Emergency Rooms (ERs), government had proposed the enactment of a law intended to improve emergency care in the country. The proposed law is intended to deter professional negligence which had occasioned many loss of lives in the past. Under the proposed law, offending medical professionals and health institutions would be sanctioned with jail terms and stiff fines as well as any other penalty imposed in the law. The draft law is meant to enforce the constitutional right of citizens to emergency medical treatment (Ndegwa 2012).

In 1997, the Tenth Congress of the Republic of the Philippines enacted the Republic Act N0. 8344 which Act

penalizes the refusal of hospitals and medical clinics to administer appropriate initial medical treatment and support in emergency and serious cases. Section 1 of the Act bars hospitals and medical personnel from requesting or demanding any form of advance payment in emergency cases as a prerequisite for medical treatment of a patient. The Act further requires hospitals and medical personnel to administer medical treatment and support as dictated by good practice of medicine to prevent death or permanent disability (The Law Phil Project 1997).

In the United States of America, although there is no universal right to be admitted to a hospital in a nonemergency situation, in such cases, admission rights depend largely on the specific hospital but basing admission on ability to pay is severely limited by statutes, regulations and judicial decisions. In addition, many states prohibit hospitals from denying admission based solely on inability to pay and some courts have made similar rulings against public hospitals (Patients' Rights 2005)

In an emergency situation however, a patient has a right to treatment regardless of ability to pay. Thus, if a situation is likely to cause death, serious injury or disability if not attended to promptly, the patient has a right to be treated whether or not he or she can pay at that time (Patients' Rights 2005). However, due to the rising and escalating cost of emergency care, many private hospitals in the early 1980s started refusing to admit indigent patients and instead had them transferred to Public hospitals. This practice, known as patient dumping, has since been prohibited by various state statutes and also by Congress (Health Care Law 2006)

To this end, in 1986, the United States Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which established criteria for emergency services and criteria for transfer of patients between hospitals. This statute which was designed to prevent "patient dumping" applies to almost all hospitals and requires hospitals to provide a screening examination to ensure that patients being transferred to other health facilities were stable for transfer. EMTALA also requires participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay. And in order to stress the importance of its intent, Congress in 2000 made EMTALA enforcement a priority with stiff penalties for non-compliance (News Media 2014)

The U.S. Supreme Court in (*Roberts v. Galen of Virginia Inc* 1999) held that patients who have an emergency medical condition who are transferred from a hospital before being stabilized may sue the hospital under the EMTALA. Under the court's ruling, even those who are not emergency patients but are victims of patient dumping, can legitimately and successfully bring an action against the hospital. In one of the first cases brought under EMTALA, a doctor transferred a woman in active labour to a hospital 170 miles away. The woman delivered a healthy baby during the trip, but the doctor was fined \$20, 000 for the improper transfer of the woman. (Patients' Rights 2005). This highlights the importance government has attached to the health matters of its citizens in those jurisdictions where statutes and case law have been used to impose restrictions on how patients are to be treated.

6. Conclusion

From the foregoing exposition, it is legitimate to conclude that to a large extent, a doctor's acceptance of patients for treatment depends on the existence of a doctor-patient relationship. Under normal circumstances, it is both legal and ethical for a doctor to refuse to treat a patient if that patient is unable to pay for the service rendered by the doctor. This is on the ground of basic business arrangement. The doctor and the hospital need money to sustain their services just like any other person in business venture. But in emergency situations, doctors in Nigeria have been shown to possess in its abundance, the milk of human kindness in that they treat patients in emergency situations without first demanding for payment even without any law compelling them to do so. Had they refused to treat in such situations, they would not have been guilty of any offence under the law. They would only have practiced contrary to the ethics of the medical profession predicated on the desire to save life in any event and to act always in the interest of the Patients.

Much as this is not so in contradiction with best practices around the world, countries like England, the Philippines, United States of America and other civilized nations have left Nigeria behind by enacting laws positively providing for the welfare of not only patients with emergency cases, but also for patients who do not require emergency treatment. These nations are able to do so principally because they have through the instrumentality of the law, put in place a health insurance policy that takes care of everyone who registers into the scheme. That way, adequate arrangement is put in place for everyone so that nobody can be legitimately denied treatment in emergency situations on account of inability to pay the bill. Nigeria could borrow a leaf from these nations in the interest of the health care of her people.

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