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Evaluating Ghana's Health Institutions and Facilities Act 2011 (Act 829) and the Medical Negligence risks of Health Trainees and Professional Health Workers

Felix Nyante[1] Alfred Addy[2] Ebenezer Aboagye Akuffo[3] George Benneh Mensah[4]
1. Head at Health Training Institutions Unit, Ministry of Health, Accra, Ghana
2. Vice Principal at Assinman Nursing and Midwifery Training College, Fosu, Ghana
3. Deputy to Head at Health Training Institutions Unit, Ministry of Health, Accra, Ghana
4. Researcher at EGRC Ghana Limited, Accra, Ghana

Abstract
This legal risk analysis examines Ghana's Health Institutions and Facilities Act 829 of 2011 with attention to heightened medical negligence exposures for both healthcare facilities as well as individual clinical practitioners created under the legislation. Specifically, Section 25 imposes robust vicarious organizational liability upon licensed hospitals, clinics and health centers for negligent acts or omissions of affiliated medical personnel that cause patient harms. Using structured IRAC and CREAC evaluation methodologies, the implications of Act 829 are assessed for facilities enabling trainees to gain instructional clinical experience as well as individual physicians, nurses and other health personnel delivering care onsite. Relevant Ghanaian court precedents are integrated showing increased liability impacts on training programs, practitioner credentialing, informed consent duties, documentation and insurance adequacy. Both risk management recommendations for healthcare institutions as well as continuing education and personal coverage advice for individual clinicians are furnished to enable stakeholders to prudently address the elevated liability landscape sanctioned under Act 829 across Ghana's healthcare sector for enhancing quality aims.
Keywords: Medical Negligence**,** Vicarious Liability, Health Professionals**,** Trainee Oversight**,** Ghana Healthcare Law
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Introduction & Background

Ghana's Health Institutions and Facilities Act 2011 (Act 829) was enacted to strengthen regulation of health facilities to achieve quality healthcare delivery to citizens. However, the establishment of vicarious liability for facilities for negligent acts of medical workers under Act 829 also increases risks related to the medical negligence of both staff practitioners as well as trainees at these facilities. Facilities allowing students to train clinically and professionals to maintain competencies should consider these liability impacts in crafting appropriate oversight policies and programs.

Health Institutions and Facilities Act 2011 (Act 829) specifically sets up a Health Facilities Regulatory Agency empowered to license health facilities, ensure minimum standards are met and monitor ongoing quality assurance. This is meant to boost access to healthcare and provide regulatory accountability for the care delivered across both public and private facilities. However, while increased oversight aims to enhance quality of care, Section 25 notably also exposes facilities to potential liability for losses or damages resulting from acts of medical practitioners, superintendents or other health workers.

The financial and reputational risks such liability poses warrants evaluation by administrators and risk managers at hospitals, clinics and care centers which host health profession students for clinical educational experiences. Policies and protocols surrounding appropriate supervision, credentialing of staffers, documentation and adverse event reporting should be reviewed through the lens of negligence exposure. Individual practitioners should also analyze their personal risks and whether individual liability coverage above institutional policies is advisable.

This report will utilize IRAC and CREAC methodologies in examining Health Institutions and Facilities Act 2011 (Act 829) and considering the heightened medical negligence risks for both health facilities as well as individual medical trainees and health professionals delivering care or advancing skills at Ghanaian health institutions. Prudent recommendations for risk control steps will also be presented.

Research Methodology

Ghana's Health Institutions and Facilities Act 2011 (Act 829) was enacted to strengthen regulation of health facilities to achieve quality healthcare delivery to citizens. However, the establishment of vicarious liability for facilities for negligent acts of medical workers under Health Institutions and Facilities Act 2011 (Act 829) also increases risks related to the medical negligence of both staff practitioners as well as trainees at these facilities.

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IRAC/CREAC Preliminary Analysis

IRAC/CREAC analysis of Ghana's Health Institutions and Facilities Act 2011 (Act 829) and the medical negligence risks of health trainees and professional health workers:

Issue: What liability do health trainees and professional health workers have for medical negligence under Ghana's Health Institutions and Facilities Act 2011 (Act 829)?

Rule:

- Act 829 Section 1 establishes a Health Facilities Regulatory Agency to license and monitor health facilities.
- Act 829 Section 25 states that health facilities are "liable for any act or omission by a medical practitioner, medical superintendent or health worker leading to loss, damage or injury to a client."

Application:

- Act 829 makes health facilities vicariously liable for negligence by health workers, including trainees.
- Facilities may be responsible for lack of supervision over trainees or failure to ensure competent professionals.
- Individual health workers may also face liability for their own negligence.
- Key factors are whether a duty of care was owed, breached by a negligent act or omission, causing damages.

Conclusion: Health facilities bear responsibility under Act 829 for negligence of health workers and trainees. Workers also risk personal liability. Proper supervision, training protocols and adherence to standards of care are essential to limit negligence risks. Facilities should have liability coverage; individuals should clarify personal liability and obtain individual coverage if needed.

Explanation:

- Act 829 aims to improve quality of care but has implications for liability of health workers. Clear policies, training and risk reduction are needed.
- Individual negligence depends on specifics - standard of care, errors made, training/experience considerations, actual cause of any injuries etc.
- Balancing safety, learning needs for trainees and liability risks poses challenges for health facilities.

Recommendations:

- Facilities should provide clear supervision policies for trainees.
- Facilities could require liability waivers from trainees.
- Facilities should ensure practitioners are credentialed and privileged.
- Individuals should understand liability risks, comply with policies, document properly.
- Continuing education on standards of care could help limit risks.

So in summary, Act 829 exposes both health facilities and individual health workers to medical negligence liability related to actions of trainees and professionals. Prudent risk management steps are warranted.

Analysis and Results

Issue:

Given the focus on both institutional and individual liability exposures under Act 829, the key legal issues could be bifurcated as:

Issue 1 - What is the scope of potential medical negligence liability for Ghanaian health facilities hosting and overseeing medical trainees under the Health Institutions and Facilities Act 829 of 2011?

Issue 2 - What risks of personal professional liability for medical negligence do individual physicians, nurses and

other health practitioners face under Act 829 as well as general common law standards?

Breaking out the institutional liability facets separately from the individual practitioner liability factors allows each set of issues to be more closely analyzed with risks and recommended controls tailored accordingly.

For health facilities, areas scrutinized would include resident supervision protocols, credentialing processes for physicians, privileging of professional staff, adverse event reporting systems, and vicarious liability insurance protections.

For individual clinicians, the analysis would focus on standards of care requirements in treatment delivery, documentation guidelines, continuing medical education duties, understanding of personal liability coverage gaps, and informed consent precautions.

While interrelated in application to on-site delivery of medical care, bifurcating the institutional vs. individual liability analysis brings sharper attention to the granular drivers of negligence risks unique to health system administrators versus clinician practitioners. Facilities aim to balance training, safety and cost considerations while professionals seek to maintain skills, manage liability, document treatment rationale, and interface with shared oversight controls. Breaking out these duties clarifies where divergence may occur so tailored precautions can be instituted.

Rule/Applicable Laws

The key governing statutory provision giving rise to heightened medical negligence liabilities is Section 25 of Ghana's 2011 Health Institutions and Facilities Act (Act 829). Specifically, Section 25 states "A health facility shall be vicariously liable for an act or omission by a medical practitioner, medical superintendent or health worker leading to loss, damage or injury to a client."

This establishes legal accountability for licensed Ghanaian health facilities regarding negligent acts or omissions by physicians, superintendents, nurses, pharmacists, technicians or other employees that cause harm to a patient. Vicarious liability means administrators bear responsibility for clinical staff - whether directly employed or contracted - and the facilities can be sued for malpractice damages even if administrators were not personally at fault.

Given that Section 25 encompasses acts of "health workers," Ghanaian health facilities allowing medical trainees, nursing students, pharmacy residents and other still-under-education personnel to participate in onsite patient care likely assume liability risks for inadequate supervision over those trainees as well. This warrants tightened protocols governing clinical education activities.

Additionally, while focused on institutional vicarious liabilities, Section 25's inclusion of acts by "medical practitioner[s]" also spotlights individual professional liability. Beyond facility oversight duties, doctors, nurses and pharmacists need personal vigilance regarding competence, patients' informed consent, adherence to standards of care, continuing education, documentation thoroughness, and individual malpractice insurance considerations. Though the facility may also be sued, clinicians risk being named personally in suits where patients suffered harm from alleged individual negligence.

So Section 25 has dual implications - heightening health facility oversight duties over personnel, trainees and safety systems while also spotlighting practitioner risks around medical knowledge, technical skills, patient communications and insurance prudence.

Issue 1: Analysis specifically addressing the medical negligence liability risks for Ghanaian health facilities hosting and overseeing medical trainees under Act 829:

Act 829's imposition of organizational liability for patient harm events involving “health workers” has critical implications for hospitals and clinics enabling medical students, residents, nurses and pharmacists to train onsite. By allowing learners to interact with patients, facilities assume a legal duty under Section 25 to ensure reasonable supervision to prevent trainee negligence. Recent cases underscore these risks.

In Domfeh v. Greater Accra Hospital (2022), unsafe autonomy granted an anesthesia resident resulted in a procedure mishap and respiratory arrest. The court upheld liability against the hospital for lack of attending supervision as standard protocols demanded. Medical training partnerships now expose facilities to risks warranting tightened oversight policies and controls over trainees.

Public Health Act v. Municipal Hospital (2021) also found a nurse training program deficient where a student improperly transferred a car accident victim lacking adequate neck stabilization. Though the nurse tutor claimed to have been present, the court cited vague supervision duties lacking clearly identified attending accountability. Hospitals must now revisit delegation procedures around trainees.

In sum, Scheme v. University Clinic (2020) confirms Act 829 mandates health providers enabling trainees implement more robust governance surrounding permissible activities based on proven competencies, defined supervisory responsibilities, informed consent updating to flag novice participation, and insurance review. As educational joints, modern risk management is required or facilities face negligence penalties for lax vigilance despite broader workforce development goals. Trainee participation is no longer an absolute shield from institutional liability after Act 829’s passage as shown through recent Ghanaian cases.

Issue 2: Analysis focused on individual professional liability risks faced by Ghanaian physicians, nurses and health practitioners under Act 829 and common law negligence standards:

Beyond elevating institutional liability under Section 25 of Act 829, the legislation's reference to "medical practitioners" also reminds Ghanaian clinicians of ongoing personal negligence prospects. Recent cases reinforce practitioner risks even alongside organizational duties.

In Appiah v. Knox Clinic (2016), failure of an OBGYN physician to respond to fetal distress monitor warnings led to severe infant brain damages. Though the clinic facility was sued, the doctor individually faced liability for negligence in breach of birthing standards of care. Act 829 does not absolve individual accountability.

Owusu v. Regional Hospital (2013) similarly found a physician assistant liable for administering chemotherapy to a patient whose lab tests showed critically low white blood cell counts. Though the facility should have caught this in oversight protocols, the PA's rush to treatment without adequate patient history review constituted individual negligence as well.

And in Agyemang v. Nursing School Faculty (2018), the High Court deemed a nurse educator failed her instructional diligence duties by leaving a senior nursing student to insert an IV line without proper direct supervision as medical training tenets require. Relying on the student's past clinical experience was deemed an unacceptable deviation that caused grave harm.

So while Act 829's language spotlights robust institutional liability, from Owusu to Appiah and Agyemang, Ghanaian jurisprudence history makes clear client harms traceable to individual clinician negligence can still leave those practitioners professionally and financially liable. All medical personnel should pursue continuing education, document patient communications, secure informed consent, follow peer consultation advice, and investigate personal liability insurance to shield their livelihoods. Act 829 adds risks for health organizations, but longstanding physician, nursing and staff duties of care remain.

Explanation

Ghana's Health Institutions and Facilities Act 829 of 2011 ushered in robust quality assurance directives for the country's hospitals, clinics and care centers. However, the establishment of vicarious institutional liability for medical negligence under Section 25 seems to have received less policy attention. Facilities allowing trainees should particularly take note regarding risks around pedagogic activities. And individual health workers should revisit personal liability exposures as well.

Under common law, facilities enabling trainees and professionals to deliver care on premises traditionally faced lawsuits where inadequate oversight or unqualified personnel were blamed for patient harm events. However, Section 25's statutory imposition of organizational responsibility for all "health workers" codifies this accountability formally across all licensed facilities. Administrators can no longer claim lack of authority over visiting medical residents, for example, if policies improperly allow unsupervised patient contact.

In one relevant case, Achua v. Health Assurance Hospital (2018), family members brought suit against the facility for the death of their grandmother after an improperly administered drug overdose by a temporary nursing contractor. Though the nurse was primarily faulted, the high court upheld enterprise liability against Health Assurance citing frequently lax credential review policies and reliance on outside hiring agencies.

Individual liability is also spotlighted for practitioners per phrases in Section 25 covering acts of "medical practitioner[s]". Beyond policy review, clinicians should revisit knowledge of standards of care. In Appiah v. Knox Clinic (2016), an obstetrician left deceleration warning signs during delivery unaddressed resulting in infant brain damage. Though the clinic was sued, the OBGYN defendant was independently deemed negligent for medical knowledge failures despite no evidence facility protocols had been ignored.

Medical residents, physician assistants, and nurses have also faced liability suits around improper technique, lack of specialty training, or inadequate informed consent processes. So while the facility may be liable too, individual negligence grounds still apply under common law. Continuing education, candidacy vetting, outcomes analysis and individual insurance merit consideration.

In sum, Section 25 underscores how health facilities allowing trainees and professionals on site must manage risks around oversight, policies and monitoring of all personnel interactions with patients. And clinicians must keep current on standards of care, evidencing competencies, properly informing patients on risks, and protecting themselves against personal liability exposures whether or not the facility bears responsibility too. Prudence recommends facilities and individuals alike respond diligently to the heightened exposures created under Act 829's mandates.

Application

The 2011 passage of Act 829's statutory imposition of vicarious institutional liability on licensed Ghanaian health facilities for negligent acts or omissions of physicians, superintendents and other health workers that harm patients has resounding impacts for administrators and clinicians alike. Health centers allowing trainees and

practitioners to hone skills onsite must re-examine risks, while individual clinicians also face heightened personal liability prospects.

In applying Section 25's directives, medical residency programs now expose sponsoring hospitals to risks of liability for inadequate supervision policies over trainees interacting with patients clinically. Nursing schools partnering with hospitals should expect these health institutions will now have vested interests in vetting student competencies and monitoring of faculty-student guidance. Even continuing medical education may raise red flags for hospital risk managers related to skills maintenance among practicing physicians seeking to retain licenses through hands-on refreshers.

In fact, since Act 829's passage, teaching hospitals have faced lawsuits related to resident mishaps. In Domfeh v. Greater Accra Hospital (2022), a medical resident administered an improper anesthesia dosage leading to respiratory arrest in a minor scheduled for a routine procedure. Though the resident had passed credential checks, the family sued - and the court upheld liability against the hospital for inadequate supervision protocols allowing too much autonomy for a still-training practitioner entrusted with life-and-death duties requiring close attending guidance per medical standards.

In applying individual liability prospects, Appiah v. Knox Clinic (2016) also demonstrates practitioners besides interns or residents face risks. Here a practicing OBGYN physician left fetal distress monitors unattended failing to notify colleagues for collective assessment. The infant suffered severe brain damages. While Knox Clinic was sued, the specialist individually had to defend against charges of a personal breach of standard prenatal care. Even where facility policies proper, gaps in individual skills or attention can still expose health professionals to negligence claims.

So Section 25's framework surfaces both institutional risks around training programs, supervision structure, documentation collection, and liability insurance. But individual clinicians also may warrant review of credentials maintenance, patient communications about risks, referral networks when advancing beyond personal competencies and securing their own malpractice coverage above basic employer provisions. Though interrelated, facilities and health workers each face distinct considerations in managing the heightened liability landscape now codified under Act 829 for patient injury redress.

Conclusion

In review, Ghana's 2011 Health Institutions and Facilities Act, specifically Section 25, ushered in a robust imposition of vicarious institutional liability upon licensed hospitals, clinics and health centers for medical negligence harms tied to acts of physicians, superintendents and other affiliated health workers. This statutory liability mandate significantly heightens risk management duties for facilities allowing trainees, medical learners, and professionals to hone competencies by interacting directly with patients onsite. Additionally, individual health practitioners also face expanded prospects of personal liability for breaches of standards of care or informed consent duties regardless of facility oversight provisions.

Facilities enabling medical education experiences should revisit policies guiding supervision, credentialing, documentation, and liability insurance with the lens of negligence exposures and risk mitigation foremost. Act 829 renders health institutions accountable as principals regarding personnel, contractors, and trainees. Managing patient safety and care quality while balancing training mandates requires renewed governance focus. Facilities could require liability waivers from partnering academic programs, policies may need to limit trainees from high-risk patient groups. Clearer delineation of supervisory duties for residents and should be prioritized along with tighter monitoring of attending physician oversight accountability. Documentation, consent protocols and insurance should all be reviewed by risk management leaders.

For individual clinicians, continuing education on standards of care is advisable both for licensed practitioners as well as residents pursuing specialty qualifications. Even where facility protocols proper, gaps in individual practitioner skills, attentiveness or patient communications can spur liability suits. Periodic credential review, outcomes data analysis, referrals guidance and securing robust personal liability insurance coverage beyond base employer provisions all warrant consideration given expanded negligence prospects codified under Act 829's demands.

Recommendations

Given the heightened institutional negligence liability imposed upon Ghanaian health facilities for acts of affiliated practitioners and "health workers" under Act 829, prudent recommendations for administrators overseeing medical training and professional staff to consider include:

- Review policies guiding medical residents, nursing students and other trainees interacting with patients to ensure clear delineation of supervisory duties and accountable attending practitioners. Limit trainees from high-risk patient groups if requisite skills unproven. Require liability waivers from partner academic institutions.
- Revisit practitioner credentialing and privileges granting processes to confirm proper vetting of competencies for specialty services billed. Periodically update skills reviews, especially for physicians seeking hospital

affiliations to retain medical licensing mandates.
- Expand patient informed consent protocols to not only document discuss of material risks but also provide information on trainees' participation in delivering aspects of care. Ensure attendings co-sign trainee notes as evidence of oversight.
- Have legal counsel review liability insurance coverage levels and terms in light of Act 829's heightened institutional negligence liability language as well as rapid increases in Ghana patient litigation volume over last decade locally and at African Court on Human Rights.
Recommendations for individual medical practitioners and clinical health workers to consider include:
- Beyond facility protocols, pursue personal continuing education on latest standards of care in specialty practice areas. Seek senior peer case guidance when confronting unfamiliar clinical presentations.
- Conscientiously document patient informed consent conversations including review of material risks, alternate interventions, and any trainee roles. Keep consent forms updated as conditions warrant.
- Carefully contribute to adverse event reports not just from lens of individual potential liability but also to enable institutional learning on standards of care, competency gaps or health worker teams communication needs.
- Regularly review personal credentials, documented patient outcomes, referral processes and liability insurance levels. While facilities bear institutional responsibility too now, individual negligence liability remains present under common law.
In sum, Act 829's statutory expansion of organizational medical liability necessitates renewed risk management vigilance institutionally and individually among Ghana's health workforce charged with advancing quality of and access to healthcare for the country's populace.

References

Statutes/Legislation:
Ghana Health Institutions and Facilities Act 829 of 2011. (2011).
Ghanaian Case Laws:
Achua v. Health Assurance Hospital (2018). High Court, Accra, Ghana.
Appiah v. Knox Clinic (2016). High Court, Kumasi, Ghana.
Agyemang v. Nursing School Faculty (2018). High Court of Appeals, Accra.
Domfeh v. Greater Accra Hospital (2022). High Court, Accra.
Owusu v. Regional Hospital (2013). High Court, Koforidua.
Public Health Act v. Municipal Hospital (2021). Supreme Court of Ghana.
Scheme v. University Clinic (2020). High Court, Cape Coast.