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Beyond awareness and semantics: Patients’ rights in tertiary health institutions in Anambra State Nigeria

Obioma Helen Onyi[1], Ngozi Chisom Uzoka[2], Tina Chinyere Dimkpa[3]
[1] Professor, Faculty of Law, Nnamdi Azikiwe University, Awka, Anambra, Nigeria
[2] Senior Lecturer, Faculty of Law, Nnamdi Azikiwe University, Awka, Anambra, Nigeria
[3] Faculty of Law, Nnamdi Azikiwe Univeristy, Awka, Anambra, Nigeria

Abstract

Tertiary health institutions are put in place by the government to provide medical care with expertise and state of the art facilities for tackling complex and sensitive health challenges. The National Health Act 2014 and the Nigerian 1999 Constitution had existed to address health matters. The Patients' Bill of Rights (PBoR) was thereafter launched in 2018, with the aim of improving health service delivery to Nigerians. Nonetheless, lack of efficient health care services still pose a serious challenge. This paper is aimed at probing into the level of awareness of patients’ rights with regards to tertiary health institutions in Anambra State, with a view to ensuring good implementation of those rights. A cross sectional survey was conducted using structured questionnaire to generate data. About 422 patients of Nnamdi Azikiwe University Teaching Hospital and Odimegwu Ojukwu University Teaching Hospital aged between 18 and 80 years were selected by simple random sample technique. The sample size of the patients population was calculated using the Cochran (1963) formula ($n = Z^2 pq/d^2$). Data entry and analysis was done using Statistical Package for Social Sciences (SPSS) version 25. Chi-square and Student t-test statistics was used to compare proportions and means respectively. Level of significance was set at $p<0.05$. The study showed that majority of the patients in the tertiary health institutions in Anambra state, Nigeria are aware of their rights however majority are unaware of the existence of the Patients’ Bill of Rights. The study recommends the enactment of legislation strictly bothering on the protection of patients’ rights which is justiciable under our law.

Keywords: Patients’ rights, tertiary health institutions, bill of rights

Introduction

Health institutions are charged with the responsibility of overseeing the affairs of patients in terms of health care and ensuring that patients’ rights are preserved. The rights of a patient are a set of rules of conduct which govern the interaction between the patients and healthcare professionals. Every patient has a right to be informed about their rights and also the responsibility of the healthcare provider [1]. The National Health Act [2] has as its aim, the establishment of a framework for the regulation, development and management of a National health system, to set standards for rendering health services in the federation and other matters concerned therewith. The Constitution [3] also accommodates provisions that bother on patients’ rights. The Patient’s Bill of Rights (PBoR) [4] is a list of guarantees for those receiving medical care and typically guarantees patient’s information, fair treatment, and autonomy over medical decisions, among other rights [5]. It may take the form of a law or a non – binding declaration [6]. The Patient’s Bill of Rights in Nigeria is an aggregation of Patient’s rights that exists in other instruments including the Constitution, the Federal Competition and Consumer Protection Act (formally the Consumer Protection Act) the Child Rights’ Act, Freedom of Information Act, National Health Act, the Hippocratic Oath, other professional ethical codes and sundry regulations. The challenge however lies in the fact that notwithstanding these laws and the launch of the Patients' Bill of Rights, a lot of patients in different health institutions in general and tertiary health institutions in particular are unaware of their sacrosanct rights as patients. These rights are constantly infringed upon with little or no recourse to legal remedy. Government non – intervention in the form of inadequate funding of tertiary health institutions is another problem to deal with. Though there are separate Bills, Charters and hospital documents regarding patients’ rights available in different settings, it is reported that the awareness among patients about these documents may be limited [7]. Situations abound where patients visit hospitals and are not attended to on time due to the inability to retrieve their hospital folders on time or inability to access the medical practitioners on time. At other times, health workers conduct themselves in a manner not befitting of their call to duty. Patients, many at times, are not carried along as far as their treatment plans are concerned making it difficult for them to appreciate their state of health at the material time in question.

Research Methodology

The research methodology employed in this study was a mixed research methodology which comprises of empirical and doctrinal research method. Doctrinal adopts approaches like analytical, comparative and historical etc. while empirical adopts field work, collection of data and analysis of same. The primary sources of data include a review of laws, Acts, Statutes, international treaties, while the secondary sources of data involves review of text books, journals articles, reports, and internet sources etc. The study is a cross sectional/descriptive study of the survey type conducted through the use of close ended questions administered to patients of the two tertiary health Institutions (Nnamdi Azikiwe University Teaching Hospital, Nnewi (NAUTH) and Chukwuemeka Odimegwu Ojukwu Teaching Hospital (COOUTH), Awka) in Anambra state, Nigeria. The study was carried out in two major Tertiary health institutions situated in Nnewi and Awka, Anambra state, over a period two months. Anambra state is one of the South Eastern states of Nigeria with a total estimated population of 9, 000,000 as at 2022 [8] and a land mass of 4,844km [9]. A total of 422 participants, (consisting of 211 patients of COOUTH, Awka and 211 patients of NAUTH, Nnewi) were recruited for the study. The study population consisted of residents from Anambra state, particularly those residing in Nnewi and Awka, where there exist major tertiary health institutions. The inclusion criteria include, first, men and women who are residents of Nnewi and Awka in Anambra state at the time of the study. Secondly, the respondents visited any of the two tertiary health institutions in Anambra state as patients. Thirdly, the respondents willingly volunteered to participate in the study. The exclusion criteria include: individuals who are below 18 years of age; those who are insane or mentally retarded; and non-residents of Anambra state, Nigeria.

The paper adopted a non-probability sampling method [10], involving, convenience purposive, and voluntary response sampling methods. The convenience sampling method requires that the individuals or respondents would be those most accessible to the researcher, that is, the participants are selected based on availability and willingness to take part in the study and in the case of this study, individuals who are residents of Nnewi and Awka in Anambra state at the time of the study. The purposive sampling method requires that the researcher will use his or her expertise to select a sample that is most useful to the purpose of the research [11] and in the case of the present study, individuals who are patients of any of the two tertiary health institutions in Anambra state. Statisticians also refer to this approach as judgmental sampling because it involves using judgment to determine which subjects can best help the study answer its research question [12]. The voluntary response sampling requires that the participants will volunteer themselves for participation in the study without coercion or inducement of any kind by the researcher [13].

Sample size estimation was determined using the formula for estimating minimum sample size for descriptive studies [1] using the formula $n = Z^2pq/d^2$ as the requisite formular [14]

where n = Desired sample size when population is more than 10,000;

Z = Standard normal deviate set at 1.96 which corresponds to 95% confidence limit;

P = Estimated proportion. Since awareness and satisfaction and level of accessibility are multivariate concepts, the researcher will assume that 50% (0.50) of the participants would have adequate awareness of the patients' bill of rights/associated laws on patients' rights as well as reasonable satisfaction and accessibility to medical care and treatment.

$Pq = (1 – p) = 1 – 0.50 = 0.50$

d = desired level of precision set at 0.05.

On applying the formular: $n = Z^2pq/d^2$

$n = (1.96)^2 \times 0.50 \times 0.50 = 3.84 \times 0.25 = 0.96 = 384$

$(0.05)^2\ 0.0025\ 0.0025$

This gave a sample size estimate of 384 participants. However, the sample size of 422 participants would be used to improve the precision of the study. This was derived by adding the result of 10 percent of the actual sample size to the actual sample size. Before data collection, informed consent was taken from all participants after explaining to them the purpose of the research and the importance of their contribution. Confidentiality of information and identity of respondents was assured. The instrument used for data collection was a questionnaire designed by the researcher to suit Nigerian environment through a robust review of the appropriate literature on rights of patients. All questionnaires were distributed by the researcher and well-trained research assistants. The collected data was analyzed using Statistical Package for the Social Sciences (SPSS) program version 25. Descriptive data was expressed as mean ± standard deviation for continuous data and percentages for categorical variables. Comparative analysis between two groups was done using non-parametric Mann-Whitney U test, while Kruskal-Walli's test was used to compare more than two groups. The chi-square test was used to test the difference between categorical (percentage) variables. Test of significance was set at $p < 0.05$. Ethical approval for the study was obtained from the Research and Ethics Committee of the two tertiary health institutions in Anambra State, Nigeria - Nnamdi Azikiwe University Teaching Hospital and Chukwuemeka Odimegwu Ojukwu Univiersity Teaching Hospital

Theoretical Foundation of Protection of Patients' Rights

This paper explored the four most prominent ethical theories in healthcare ethics that inform peoples' actions and beliefs, from every day moral decisions to more abstract ethical dilemmas. These are utilitarianism, deontology, virtue ethics and principlism [15]. Hendricks [16] views that ethical theory can be difficult to understand because it can appear abstract and irrelevant to everyday practice; but it need not be. An easy way to think of ethical theory is to see it simply as the attempt to identify and classify moral standards or rules that should, or do, guide our behavior [17].

1. Utilitarianism

According to Hendricks, Utilitarianism is a widely adopted moral theory that is the best- known example of consequentialism, a class of moral theories that are solely concerned about the consequences of our actions—whether they bring about the desired results. In effect, the end justifies the means. Morally right acts are those that maximize (increase) utility—and maximize it for everyone, not just individuals. This is often expressed as 'the greatest happiness for the greatest number [18]'

2. Deontology

Deontology, by contrast, is concerned with certain features of an ethical theory that can appear abstract and irrelevant to everyday practice; but it is action itself. The end is never justified by the means; 'some choices cannot be justified by their effects—that no matter how morally good their consequences, some choices are morally forbidden [19]' A well-known example of a deontological system is the Universal Declaration of Human Rights (UN General Assembly, 1948), which states that certain actions such as torture are intrinsically wrong [20] While deontological systems have an advantage over utilitarianism in that they usually imply many scenarios that seem intuitively wrong are immoral (such as sacrificing one person to obtain their organs for the benefit of many) this can turn to disadvantage in catastrophic situations, such as where torturing one person is required to save one million people [21].

3. Virtue Ethics

Virtue ethics (VE) is considered to be the oldest of the four ethical theories we are exploring, owing its origins to Aristotle back in the fourth century BC and further developed by Thomas Aquinas in the thirteenth century [22]. What distinguishes virtue ethics from the other ethical theories is that it is less concerned with what we do (action) and more so with who we become (character) over time [23]. According to VE, doing the right thing is not about following a set of rules (deontology) or trying to bring about the most pleasure or happiness (utilitarianism)—it is about becoming the right sort of person by seeking to acquire certain virtues. A virtue is a type of good disposition (or tendency) to act in one way instead of another [24].

4. Principlism

Although principlism is not strictly an ethical theory, it is the most widely used moral framework for guiding conduct in healthcare, and is clearly relevant to the HCA [25]. Beauchamp and Childress [26] first described its four ethical principles as a way to help structure moral thinking and to inform ethical decision- making. The principles are: autonomy, beneficence, non- maleficence and justice. The strength of this approach is that the four principles are based upon what Beauchamp and Childress call ‘common morality’. The four principles draw on aspects of all three moral theories discussed so far in an attempt to provide a practical approach to moral decision-making [27]. Autonomy as a first principle describes the importance of letting patients make their own decisions about their care. Beneficence as a second principle means making sure that whatever an HCA does, they are considering what will benefit the patient; the goal is always to do good. The third principle is non-maleficence, which means to avoid doing patients harm; the goal is always to minimize any unnecessary harm to patients or colleagues. The fourth principle is justice. It describes the importance of treating people fairly, making sure that none is receiving more favourable treatment than another or is being discriminated against [28].

Level of Awareness of Patients’ Rights Amongst Patients in Tertiary Health Institutions in Anambra State, Nigeria

Table 1: Socio-Demographic Characteristics of the Study Population

Participants’ Characteristics		Location of Study		All
		Couth Awka	Nauth Nnewi	
Gender	Females	112 (53.1)	133 (63.0)	245 (58.1)
	Males	99 (46.9)	78 (37.0)	177 (41.9)
Age group	Young Adults	133 (63.0)	79 (37.4)	212 (50.2)
	Middle-Aged	64 (30.3)	102 (48.3)	166 (39.3)
	Elderly	14 (6.6)	30 (14.2)	44 (10.4)
Religion	Christianity	186 (88.2)	207 (98.1)	393 (93.1)
	Islam	12 (5.7)	4 (1.9)	16 (3.8)
	Traditional	13 (6.2)	0 (0.0)	13 (3.1)
Marital Status	Divorced	3 (1.4)	7 (3.3)	10 (2.4)
	Married	108 (51.2)	130 (61.6)	238 (56.4)
	Separated	2 (0.9)	1 (0.5)	3 (0.7)
	Single	93 (44.1)	62 (29.4)	155 (36.7)
	Widowed	5 (2.4)	11 (5.2)	16 (3.8)
Level of Education	Non-Formal	15 (7.1)	0 (0.0)	15 (3.6)
	Primary	16 (7.6)	23 (10.9)	39 (9.2)
	Secondary	74 (35.1)	100 (47.4)	174 (41.2)
	Tertiary	106 (50.2)	88 (41.7)	194 (46.0)
Occupation	Unemployed	36 (16.1)	27 (12.8)	47 (14.5)
	Farming	15 (7.1)	11 (5.2)	26 (6.2)
	Trading	82 (38.9)	71 (33.6)	153 (36.3)
	Artisanship	10 (4.7)	20 (9.5)	30 (7.1)
	Public Service	69 (32.7)	75 (35.5)	144 (34.1)
	Retired	1 (0.5)	7 (3.3)	8 (1.9)
Ethnicity	Ibo	190 (90.0)	199 (94.3)	389 (92.2)
	Hausa	7 (3.3)	3 (1.4)	10 (2.4)
	Yoruba	6 (2.8)	3 (1.4)	9 (2.1)
	Others	8 (3.8)	6 (2.8)	14 (3.3)

Table 1 shows the socio-demographic characteristics of the study population. The study population comprises 422 patients recruited from both Nnamdi Azikiwe University Teaching Hospital, Nnewi (n = 211) and Chukwuemeka Odimegwu Ojukwu Teaching Hospital, Awka (n = 211). Majority of the respondents from both health facilities and overall were: females (COUTH, 53.1%; NAUTH, 63%; All, 58.1%); Christians (COUTH, 88.2%; NAUTH, 98.1%; All, 93.1%); married (COUTH, 51.2%; NAUTH, 61.6%; All, 56.4%) and Ibos (COUTH, 90%; NAUTH, 94.2%; All, 92.2%). A greater percentage of the patients from COUTH (63%) and overall (50.2%), were of the young adult age (18-35 years), while most of the patients from NAUTH (48.3%) were of the middle-aged group (35 – 59 years). The overall mean age of the participants was 38.3 years (standard deviation, 14.2 years; range, 18 – 94 years). Most of the respondents from COUTH (50.2%) and overall (46%) had tertiary education, while a higher proportion (47.4%) of patients from NAUTH had secondary education. A greater percentage of the patients from COUTH (38.9%) and overall (36.3%) were traders, while most of the patients from NAUTH were public servants (35.5%).

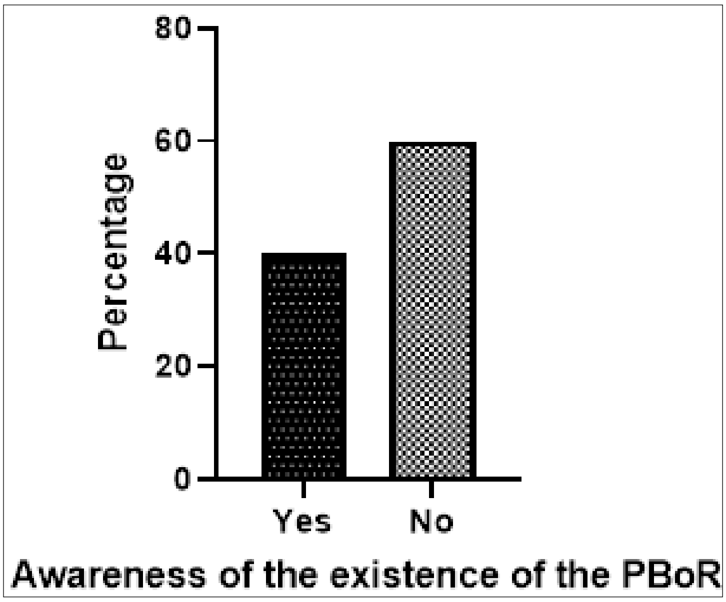

Fig 1: The Awareness of the Existence of the Patients' Bill of Rights by Participants

A greater percentage (60%) of the participants indicated that they were not aware of the existence of the patients' bill of rights while 40% reported that they had seen and read the contents of the patients' bill of rights.

Table 2: Knowledge of Participants about Different Elements of Patients' Rights

SN	Statement Variables	Yes	No
1	I know I have the right to relevant information in a language and manner I understand as a patient including diagnosis, treatment, other procedures and possible outcomes.	372 (88.2)	50 (11.8)
2	I have the right to timely access to detail and accurate medical records and available services.	359 (85.1)	63 (14.9)
3	I know I have the right to transparent billing and full disclosure of any costs, including recommended treatment plans.	378 (89.6)	44 (10.4)
4	I know I have the right to privacy, and confidentiality of medical records.	383 (90.8)	39 (9.2)
5	I know I have the right to clean, safe, and secure healthcare environments.	390 (92.4)	32 (7.6)
6	I know I have the right to be treated with respect, regardless of gender, race, religion, ethnicity, allegations of crime, disability or economic circumstances.	401 (95.0)	21 (5.0)
7	I know I have the right to receive urgent, immediate and sufficient intervention and care, in the event of an emergency.	397 (94.1)	25 (5.9)
8	I know I have the right to reasonable visitation in accordance with prevailing rules and regulations.	399 (94.5)	23 (5.2)
9	I know I have the right to decline care, subject to prevailing laws and upon full disclosure of the consequences of such a decision.	376 (89.1)	46 (10.9)
10	I know I have the right to decline or consent to participate in medical research, experimental procedures or clinical trials.	377 (89.3)	45 (10.7)
11	I know I have the right to quality care in accordance with prevailing standards.	397 (94.1)	25 (5.9)
12	I know I have the right to complain and express dissatisfaction regarding services received.	393 (93.1)	29 (6.9)

Table 2 shows the knowledge of participants about different elements of patients' rights. Majority of the respondents reported they were aware that: they have the right to relevant information in a language and manner they understand as patients including diagnosis, treatment, other procedures and possible outcomes (88.2%); they have the right to timely access to detail and accurate medical records and available services (85.1%); they have the right to transparent billing and full disclosure of any costs, including recommended treatment plans (89.6%); have the right to privacy, and confidentiality of medical records (90.8%); have the right to clean, safe, and secure healthcare environments (92.4%); have the right to be treated with respect, regardless of gender, race, religion, ethnicity, allegations of crime, disability or economic circumstances (95%); have the right to receive urgent, immediate and sufficient intervention and care, in the event of an emergency (94.1%); have the right to reasonable visitation in accordance with prevailing rules and regulations (94.5%); have the right to decline care, subject to prevailing laws and upon full disclosure of the consequences of such a decision (89.1%); have the right to decline or consent to participate in medical research, experimental procedures or clinical trials (89.3%); have the right to quality care in accordance with prevailing standards (94.1%); have the right to complain and express dissatisfaction regarding services received (93.1%).

Table 3: The Participants' Knowledge Score about Patients' Rights

Statistical Variables	Values
Number of Participants	422
Mean Knowledge Score	10.95
Standard Deviation	2.58
Range	0 – 12
Median Score	12.0
Shapiro Wilk's Test of Normality	0.455 (p < 0.001)

Knowledge score rating: Yes = 1; No = 0.

The knowledge score of the participants regarding Patients` Bill of Rights is as shown in Table 3. Data showed that the mean (±SD) score of the knowledge of the participants regarding Patients` Rights was 10.95 ± 2.58. The score ranged between 0 and 12 (out of a maximum of 12) with a median score of 12. Shapiro Wilk's test of normality indicated that total knowledge score about Patients` Rights was abnormally distributed (0.455; p < 0.001).

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Table 4: Association of Participants' Characteristics with Knowledge Score Regarding Patients` Rights

Characteristics	Number of Participants	Mean ± SD	Mean Rank	P – Value
Location				0.001
NAUTH Nnewi	211	10.47 ± 3.23	195.5	
COUTH Awka	211	11.42 ± 1.58	227.4	
Gender				0.563
Females	245	11.06 ± 2.33	213.8	
Males	177	10.79 ± 2.90	208.3	
Age Group				0.008
Young Adults	212	11.39 ± 1.78	225.0	
Middle Aged	166	10.46 ± 3.33	201.6	
Elderly	44	10.66 ± 2.33	183.4	
Religion				0.389
Christianity	393	10.97 ± 2.55	212.3	
Islam	16	9.93 ± 3.97	180.6	
Traditional	13	11.53 ± 0.96	224.6	
Marital Status				0.036
Single	155	11.37 ± 2.02	229.8	
Married	238	10.68 ± 2.88	200.8	
Widowed	16	11.37 ± 1.50	213.0	
Divorced	10	10.30 ± 3.77	201.3	
Separated	3	10.66 ± 1.52	137.6	
Educational Status				0.170
Non-Formal	15	11.86 ± 0.35	248.5	
Primary	39	11.23 ± 1.66	212.6	
Secondary	174	10.40 ± 3.45	201.1	
Tertiary	194	11.31 ± 1.69	217.7	
Occupation				0.524
Students/Unemployed	61	11.59 ± 0.78	223.5	
Public Service	144	11.12 ± 2.25	213.4	
Farming	26	10.80 ± 3.22	210.1	
Trading	153	10.67 ± 3.12	211.2	
Artisanship	30	10.56 ± 2.66	195.0	
Retired	8	10.12 ± 2.74	159.2	
Ethnicity				0.353
Ibo	389	10.97 ± 2.54	212.4	
Hausa	10	9.40 ± 4.97	184.4	
Yoruba	9	11.66 ± 1.0	246.0	
Others	14	10.92 ± 1.68	181.9	
Awareness of PBoR Existence				<0.001
No	253	10.45 ± 3.15	190.8	
Yes	169	11.70 ± 0.96	242.4	

As shown in Table 4, there was association between knowledge score for patients' rights and the study location. Mann Whitney U test indicated a significantly higher knowledge score among patients attending COUTH in Awka compared with those attending NAUTH Nnewi (p = 0.001). There was a statistically significant decrease in the level of knowledge regarding PBoR with advancing age of participants as the mean rank of the total knowledge score was 225.0 among young adults and declined to 201.6 and 183.4 among the middle-aged and elderly respectively (p = 0.008). There was a significant association between knowledge score and marital status of the participants (p =

0.036) and their awareness of the existence of PBoR ($p < 0.001$). Patients who were single had a higher mean rank compared with those who were married, divorced and separated. There was also statistically higher knowledge score among those who were aware of the existence of PBoR compared with those who were not aware of PBoR existence ($p < 0.001$). In contrast, no significant differences were found in knowledge score for patients' rights between genders ($p = 0.563$), among different religions ($p = 0.389$), educational levels ($p = 0.170$), different occupations ($p = 0.524$), and different ethnic groups ($p = 0.353$).

Summary and Discussion of Findings

For the purposes of having a more comprehensive and holistic list of rights which bothers on patients' protection, the rights provided for in the patients' bill of rights were adapted for this study. The study has proven that a greater percentage (60%) of the participants indicated that they were not aware of the existence of the patients' bill of rights while 40% reported that they had seen and read the contents of the patients' bill of rights. The patients' bill of rights 2018 is the only document that deals strictly on patients' rights in Nigeria and in a very comprehensive manner hence the adaptation of its content for this research. The National Health Act 2014 bothers on health rights and is not a legislation bothering strictly on patients' rights. This paper has shown that health rights and patients' rights are entirely different. While health rights apply to everyone by virtue of his humanity, the rights of patients apply only to patients and can be enforced by only those in Doctor – patient relationship where there is a breach [44]. It is important to observe that the National Health Act 2014 had been in existence before the launching of the Patients' Bill of Right in 2018. It is therefore logical to infer that the need to have a legal document that strictly bothers on patients' rights must have necessitated the birthing of the Patients' Bill of Rights in Nigeria. The importance of the Patients' Bill of Rights was highlighted by a Lead Consultant, National Program of Action for the Strengthening of Patients' Bill of Rights when he stated that the Patients' Bill of Rights is a set of guidelines that specifies the rights and responsibilities of patients when receiving medical care. It is designed to protect patients' rights, promote their safety, and ensure that they receive high-quality medical care that meets their needs. The Bill of Rights also ensures that patients have access to information about their health status, diagnosis, treatment options, and the risks and benefits of any medical procedure [45].

Olusegun *et al* observed that the rights of patients in Nigeria highlighted in the Patients' Bill of Rights have been continuously hindered by their weak enforcement, inadequate funding, insufficient health care providers, inadequate infrastructure, lack of awareness and illiteracy and concluded that urgent steps need to be taken by Nigerian government as well as other relevant stakeholders in addressing these issues [46]. The present study confirmed that lack of awareness of the patients' bill of rights is a contributing factor to the hindering of protection of patients' rights. Adekoya recommended that 'assertive communication strategies' and public enlightenment are needed to sensitize and empower patients on their rights and liberty to complain when such rights are violated [47]'. The researcher therefore opines that awareness of the existence of the Patients' Bill of Rights is very fundamental and crucial to their enforcement. The challenge however remains with the fact that the Patients' Bill of Right with all its importance and detailed and holistic provisions is not a statutory legislation and is not justiciable. It is also observed that the Patients' Bill of Rights, though strictly on patients' rights does not provide for sanctions in the event of violation of the rights it tends to protect. It also needs to be beefed up to make provision for all the rights in other enactments that are not included in the Patients' Bill of Rights. For example, the provisions in the National Health Act that makes provision against removal of tissue, blood, or blood product from the body of another living person for any purpose except within the permitted exceptions [8] and also the prescribed sanctions [9]. Further provisions regarding tissue and blood were also provided for by the Act which is relevant [10].

The study showed that compared to other occupational categories most of the participants were traders. This factor most likely informed the outcome of the research as far as awareness of the patients' bill of rights is concerned. It is reported that Anambra state has indigenous ethnic groups as Igbo (98%) and a small population of Igala (2%). Onitsha and Nnewi however are the biggest commercial cities in the state. The major occupations in the state are farming and trading [48].

The study suggests that the participants showed very good knowledge of their specific rights as patients with the mean knowledge score of 10.95. This is similar with a related study which showed that 100% of the study participants were aware of the rights of patients in healthcare facilities [49]. However the difference lies in the fact that the earlier study involved medical practitioners as the respondents while the present study involved patients as respondents.

The present study showed that the knowledge of the patients' rights was influenced by the study locations, age group, marital status and awareness of the existence of the Patients' Bill of Rights. Our finding showed that patients from COOUTH Awka had more knowledge of their rights compared to those from NAUTH. This may be due to the fact that COOUTH is situated in more cosmopolitan environment than NAUTH. The former has more of civil servants within its environs while the latter has predominantly traders whose perception on issues, bothering on patients' rights, differs from their Nnewi counterpart, based on interaction with the respondents by the researcher. The younger adults indicated significantly higher knowledge of patients' rights compared to the middle aged and elderly. This may be attributed to the fact that they have easy access to internet facility and other technological aides and gadgets that informed them about these rights compared to their older counterparts. The study also showed that marital status affected the level of knowledge of patients' rights with the singles and widowed indicating higher knowledge score compared with other marital status. The reason for this is not clear. However it is the view of the researcher that singles are often times associated with less responsibility. Additionally, those who were aware of the PBoR existence were more knowledgeable about patients' rights. This was expected since they had knowledge of the PBoR compared to those who were not aware of its existence. However there was no significant relationship observed between the knowledge of patients' rights and gender, educational status, religion, ethnicity and occupation as shown in Table 4.

Conclusion

On the basis of the findings from this research work, it is clear that although majority of the patients in these tertiary hospitals in Anambra State, Nigeria were knowledgeable about their rights as patients, the laws protecting these rights are not adequate since they do not strictly bother on patients' rights. Majority of the patients were unaware of the existence of Patients' Bill of rights which makes reasonably adequate provision for rights of patients strictly. However, the said Patients' Bill of Rights is not justiciable or enforceable in the law courts. Chapter II of the 1999 Constitution that provides for right to health care is not extensive enough to cover broad patients' rights and most unfortunately, is also not justiciable. There is also no State law in Anambra State strictly bothering on patients' rights protection. The National Health Act, 2014, though a legislative enactment that has specific provisions on rights of patients is not holistic enough and is not strictly an enactment of patients' rights protection.

Recommendations

1. There is a need to enact a law that bothers strictly on patients' rights both at the federal and state level in a very extensive and comprehensive manner and to also make such law justiciable and enforceable. This law can take the form of a legislative enactment or there can be a constitutional amendment creating a chapter on patients' right protection and making same justiciable albeit subject to available resources of the government which should be made more responsive to and responsible for the plights of patients in Nigeria in general and in Anambra State in particular.
2. There should also be establishment of agencies responsible for sensitization of the public regarding their rights as patients, and also of existing laws ensuring such protection of rights as well as enforcement mechanisms in place towards actualization of patients' rights protection.
3. The judiciary in Nigeria, should be more responsive and exhibit more activism in advancing the laws protecting patients' rights in order to boost confidence of patients in Anambra State judiciary in particular and by extension Nigerian judicial system as far as patient' rights protection is concerned. This is simply because the judiciary is believed to be the last hope of the common man.
4. Service delivery in tertiary hospitals in Anambra State Nigeria by health practitioners should be upgraded to the optimal level considering how crucial issues regarding health or patients' rights are concerned. In a nutshell, Doctors, nurses, and other health workers should prioritize protection of patients' rights above personal gains.
5. There is need for the Anambra State Government in particular to make health care a priority and consequently to adequately fund the tertiary health institutions within the state. Proper and adequate funding would give rise to equipping of the facilities in question with the requisite state of the art equipment for use by the already trained practitioners, proper and adequate remuneration of health workers in order to have in these hospitals health workers who will be more inclined and happy to give patients the best of care than going on incessant and avoidable strikes, to the total neglect of patients.

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